Nurses must guard against pain that can interfere with their work and take the pleasure out of their off-duty hours. Keep "217" Tablets readily available for fast protection when pain threatens or strikes. The handy tube fits conveniently in pocket or purse. The economy sizes of 40 and 100 tablets are ideal for home or office use.

Relieve

HEADACHES

NEURALGIA

RHEUMATIC PAIN

and COLDS

Charles E. Frosst & Co.
MONTREAL CANADA

Between Ourselves

To many nurses **Florence H. M. Emory** is best known for her book on public health nursing. To those nurses who have attended the University of Toronto, she is the kindly counsellor, with a rich store of knowledge of nursing affairs and activities. To those of us whose nursing experience includes the black years of the depression, Miss Emory stands out as the person who, as president of the Canadian Nurses' Association, 1930-34, took the lead in the many important developments of that period. It was during her tenure of office that the first survey of nursing education in Canada was successfully concluded. She envisioned the possibilities for enlarging the scope and usefulness of *The Canadian Nurse* when she sponsored the employment of the first full-time editor and business manager.

In this issue Miss Emory's facile pen has given us her picture of the problems and possibilities that face nursing in this year, 1950. Read her article with a consciousness of the background of knowledge and authority with which she speaks. This material was given as an address at a refresher course held under the auspices of the School of Nursing of the University of Toronto last autumn.

* * *

Our guest editor this month, **Jean S. Clark,** president of the Alberta Association of Registered Nurses, is a native daughter with as broad a perspective in nursing as the far expanses of her prairie province. Graduating in 1940 from the University Hospital in Edmonton, she completed the work for her bachelor of science in nursing degree the following year at the University of Alberta. After four years of experience in public health nursing, she was awarded a Rockefeller fellowship for advanced study at Johns Hopkins University, Baltimore, Md. Returning to Alberta, she became director of the public health nursing division with the Alberta Department of Public Health. When the federal health grants to the provinces were announced in 1948, Miss Clark was relieved of her provincial duties to participate in the activities of the Alberta Health Survey Committee. The account she has given us of the nursing activities in her province brings a picture as warming as the Chinook that blows over her beloved foothills.

* * *

Have nurses anything to contribute to the architects who design our hospitals? When they have to walk nearly the equivalent of a city block to fetch and carry for their patients, many nurses feel that they would like to condemn the architect to just one day of hurrying back and forth between a utility room that is inconveniently placed, a kitchen that has few of the modern inventions that ease a housewife's chores, and a 15- or 20-bed ward. **Bianca Beyer,** who had had practice in remodelling an old school building into a workable, efficient, well-planned hospital, gave the architects of Toronto some valuable pointers in the course of an address which she delivered to them. Her article, an adaptation of this address, may strengthen the hands of many nurses during this period when the tremendous surge of hospital construction is adding new units in so many communities.

* * *

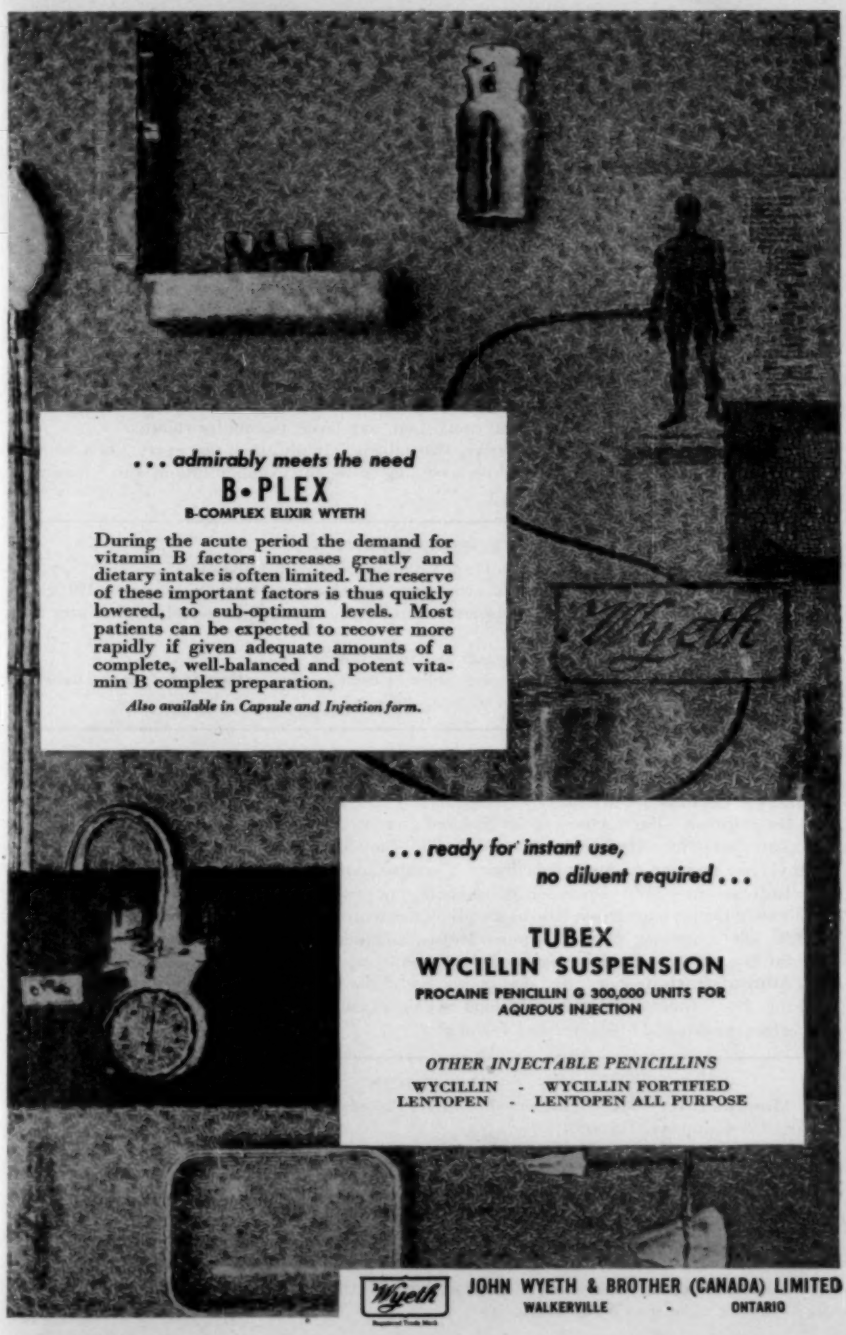
We would like to call your attention to the article on the Student Nurse Page. **Methemoglobinemia** is a relatively unknown disease and Miss MacLachlan has given us a good description of it, together with an understanding of the essential nursing care.

* * *

Peterborough, Ont., has a very active chapter. Last season they sponsored a refresher course, several of the papers for which are included in this issue. Sister St. Agnes, operating-room supervisor at St. Joseph's Hospital, gave a demonstration of the various **anesthetic agents** currently being used and, together with Dr. Wishart and Miss Barnett, showed the set-up of the anesthetic bed and table and the reception of the patient following anesthesia.

* * *

Our Cover—*We are indebted* to Aubra Cleaver for permission to use this photo from her collection, taken and presented to the Child Health Centre, Goderich, Ont., by Ann Wurtele.



. . . admirably meets the need

B•PLEX

B-COMPLEX ELIXIR WYETH

During the acute period the demand for vitamin B factors increases greatly and dietary intake is often limited. The reserve of these important factors is thus quickly lowered, to sub-optimum levels. Most patients can be expected to recover more rapidly if given adequate amounts of a complete, well-balanced and potent vitamin B complex preparation.

Also available in Capsule and Injection form.

. . . ready for instant use, no diluent required . . .

TUBEX WYCILLIN SUSPENSION

PROCAINE PENICILLIN G 300,000 UNITS FOR AQUEOUS INJECTION

OTHER INJECTABLE PENICILLINS

WYCILLIN - WYCILLIN FORTIFIED
LENTOPEN - LENTOPEN ALL PURPOSE

Wyeth

JOHN WYETH & BROTHER (CANADA) LIMITED
WALKERVILLE - ONTARIO

New Products

Edited by **PROFESSOR F. N. HUGHES**

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

COLMIN Tablets and Nasal Solution

Manufacturer—Canada Pharmacal Co. Ltd., London, Ont.

Description—*Colmin Tablet:* Each contains the antihistaminic, Diphenhydramine hydrochloride 0.20 mg., Acetylsalicylic acid 0.23 gm., Phenacetin; 0.15 gm., Desoxyephedrine hydrochloride 1 mg.

Colmin Nasal Solution: Contains Diphenhydramine hydrochloride 0.5% and Naphazoline hydrochloride (2-(naphthyl-methyl) Imidazoline hydrochloride) 0.33% in a buffered isotonic solution.

Indications—Incipient cold, nasal congestion, hay fever, vasomotor rhinitis.

Administration—As a cold abortive, two tablets initially, then one every 3 or 4 hours for 3 or 4 days, or as prescribed. Children according to weight. Nasal Solution, 3 to 5 minims in each nostril as required.

ANCATROPINE INFANT S.T.

Manufacturer—Anglo-Canadian Drug Company Limited, Oshawa.

Description—Each soluble tablet contains: Homatropine methylbromide 1/250 gr., Phenobarbitone sodium 1/16 gr. The tablets are especially designed for dissolving in water or milk.

Indications—Gastro-intestinal spasm and hypertonicity.

Administration—Average dose, one tablet at each feeding, either added to the baby's formula or dissolved in a teaspoonful of water or milk.

'SYNDROX' HYDROCHLORIDE

Manufacturer—McNeil Laboratories, Inc., Philadelphia, U.S.A.; Canadian distributors: Vanzant & Company, Toronto.

Description—Each scored tablet (colored green) contains 5 mg. Sandrox hydrochloride (Methamphetamine Hydrochloride, 'McNeil'), the hydrochloride of dextro-1-phenyl-2-methylaminopropane (d-desoxyephedrine), a sympathomimetic amine.

Indications—Mild depression or asthenia, obesity where control of appetite is a predominating factor, narcolepsy. Also as an adjunct in treatment of acute and chronic alcoholism, Parkinson's syndrome, cerebral arteriosclerosis, and migraine. Contraindicated in coronary arterial disease, hypertension, myocardial degeneration, hyperthyroidism, and insomnia.

Administration—Suggested dosage is 2.5 to 5 mg. daily initially, then increased to 2.5 to 5 mg. 2 or 3 times daily and maintained so long as there are no outward effects. Best times are before breakfast, 11.00 a.m., and 4.00 p.m.

AMOTRICIN

Manufacturer—McNeil Laboratories, Inc., Philadelphia, U.S.A.; Canadian distributors: Vanzant & Company, Toronto.

Description—Each pleasantly-flavored lozenge contains:

Tyrothricin	1 mg.
Cetyl dimethyl benzyl ammonium chloride	5 mg.
Orthesin (Benzocaine, 'McNeil')	3.5 mg.

Indications—Antibiotic and anodyne for throat infections especially those caused by gram-positive cocci.

Administration—Allow one to dissolve slowly in the mouth every 2 or 3 hours as necessary (but not more than 8 lozenges a day).

POTENCY

The comprehensive controls under which Aspirin is made insure uniform potency. In all, over seventy different tests and inspections are employed in making this best-known of all analgesics. The Aspirin reputation and acceptance as *the* analgesic for home use is being jealously guarded. In one of the world's finest drug plants where Aspirin is made, *excellence* is the standard.

May we send you a liberal supply of professional samples?
Write: The Bayer Company Ltd., 1019 Elliott Street, W., Windsor, Ont.
"Aspirin" is the registered trade mark in Canada of the Bayer Company Limited

SORPARIN

Manufacturer—McNeil Laboratories, Inc., Philadelphia, U.S.A.; Canadian distributors: Vanzant & Company, Toronto.

Description—Tablets containing 3 gr. of alcoholic extractive of the berry of the European Mountain Ash (Sorbus aucuparia).

Indications—Suggested for liver dysfunction as in hepatitis, indeterminate dyspepsia, post-surgical biliary syndrome, idiopathic hypoprothrombinemia.

Administration—Two tablets 3 times daily with a little water before meals.

'HISTADYL' and 'SURFACAINE' Lotion and Cream

Manufacturer—Eli Lilly and Company (Canada) Limited, Toronto.

Description—'Histadyl' (Thenylpyramine Hydrochloride, Lilly) and 'Surfacaine' (Cyclomethycaine, Lilly):

Lotion M-64 contains in each 100 cc. 'Histadyl' 2 gm., 'Surfacaine' 0.5 gm., calamine 8 gm., zinx oxide 8 gm.

Cream No. 6 contains 'Histadyl' 2%, 'Surfacaine' 0.5%, is a non-irritating, hypo-allergenic base.

Indications—Allergic dermatoses assosiated with severe itching and discomfort, burns, abrasions, dermatological lesions, solar erythema, insect bites. Cream No. 6 is especially suggested as a local analgesic in pruritus ani et vulvae.

CAFERGONE Tablets

Manufacturer—Sandoz Pharmaceuticals Ltd., Montreal.

Description—Each tablet contains ergotamine tartrate 1 mg. and caffeine 100 mg.

Indications—Migraine and tension headache.

BACIDRIN

Manufacturer—The Upjohn Company, Toronto.

Description—Antibiotic nasal decongestant in dry form. When contents of one bottle are dissolved in water to make 15 cc., each cc. of the resulting buffered isotonic solution contains:

Bacitracin	200 units
Ephedrine hydrochloride	5 mg. (0.5%)
Myristyl-gamma-pincolinium chloride	1:10,000

Indications—Upper respiratory infections associated with inflammation and congestion of nasal mucosa, as in the common cold; infectious rhinitis, nasopharyngitis, and sinusitis.

Administration—As nose drops or nasal spray every 2 to 4 hours. The solution is stable for 1 week if stored in refrigerator. Dry form is stable for 1 year at room temperature.

NEO-ANTERGAN EXPECTORANT

Manufacturer—Poulenc Laboratory Limited, Montreal.

Description—Neo-Antergan Expectorant combines the well-known antihistaminic Neo-Antergan and Ephedrine in an aromatic, pleasant tasting excipient. 1 teaspoonful (4 cc.) of Neo-Antergan Expectorant contains:

Neo-Antergan	20 mg.
Sodium citrate	43 mg.
Tr. cocillana	0.36 cc.
Promoform	2 mg.
Ephedrine Hydrochloride	10 mg.
Ammonium chloride	80 mg.
Menthol (crystals)	0.4 mg.

Indications—Asthma, cold, or bronchitis of allergic origin, vasomotor rhinitis, or any other respiratory complaint associated with an allergic condition.

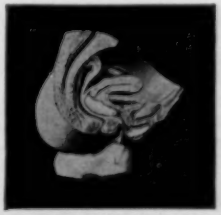
Administration—Adults: 1 to 2 teaspoonfuls every 3 hours, or as directed by physician. Children: Half dose.

so safe...

The more than two billion TAMPAX tampons purchased in the past twelve years (plus extensive clinical tests*) bespeak the inherent safety of these dainty intravaginal cotton guards.
They do not cause vaginitis or erosion, and cannot block the flow.
The three absorbencies (Regular, Super, Junior) individualize menstrual hygiene —and are amazingly comfortable and convenient, and thoroughly adequate.

*West. J. Surg., Obstet. & Gynec., 51:150, 1943; J.A.M.A. 128:490 1945; Am. J. Obst. & Gynec., 48:510, 1944, etc.

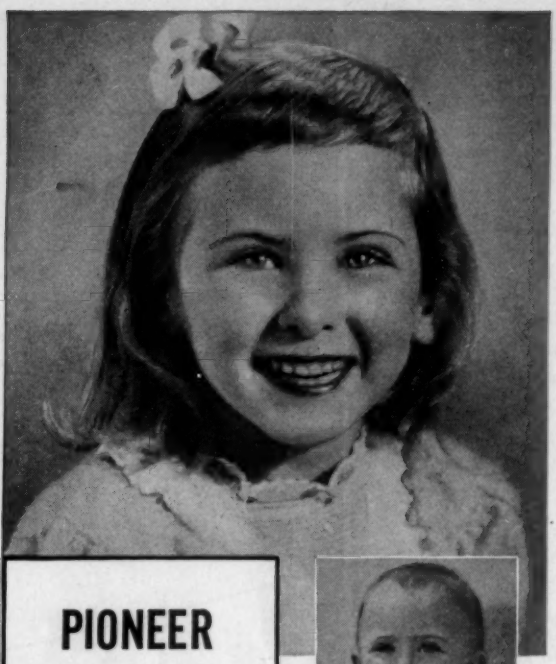
Canadian Tampax Corporation Limited, Brampton, Ontario



the internal menstrual guard of choice TAMPAX

Your request will bring related literature and professional samples promptly.

ACCEPTED FOR ADVERTISING BY THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION



PIONEER MEAT EATER

(5 years later)

Five years ago, little Betsy Traynor was a participant in Swift's Meats for Babies first feeding test.

Way back when Betsy started Swift's Meats, meat was a "revolutionary" food for a baby. Betsy and her fellow participants were the first babies *ever* to eat Swift's specially prepared strained meats. Many of the infants in this original group were only six weeks old at the time!

Betsy's bubbling good spirits and sound, sturdy development testify to the benefits of regular meat-feeding early in life. And Betsy's mother will tell you, "She's the very picture of health!"

Today any baby can have the same right start in life that lucky little Betsy had. Doctors recommend Swift's Meats for Babies now in the early weeks of life—to provide the complete high-quality proteins and iron every infant needs every day for sound growth and development.

Swift prepares an appetizing variety of: beef, lamb, pork, veal, liver and heart—to help infants form sound eating habits.

Swift's Meats for Babies are expertly trimmed to minimize fat content—carefully cooked to preserve a maximum of essential meat nutrients. Swift's Strained Meats for Babies—Diced Meats for Juniors—are convenient and economical, cost less than home-prepared meats.

All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.

SWIFT QUALITY FOODS

SWIFT

... foremost name in meats

... first to develop and clinically test 100% Meats for Babies

Current Clinical Meat Feeding Studies

REPORT No. 1

MEAT FOR ALLERGY FEEDING

From this research has evolved a milk substitute for feeding to allergic infants and children who cannot tolerate milk. The formula, which may be easily made up by the mother, consists of Swift's Strained Beef supplemented with calcium, phosphorus salts, carbohydrate and fat. Studies show that the calcium, phosphorus and protein are utilized as well as these same nutrients when derived from milk.

This study on the nutritional value of a meat formula is part of an extensive clinical research program now being conducted through grants-in-aid made by Swift.

In The Flexible Comfort of your Spencer

Bending, Stooping, Lifting won't tire you so!

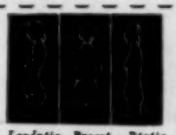
Have a Spencer designed especially for you and enjoy stimulating support!

You'll react *spontaneously* to its gentle posture guidance by carrying your body in *restful*, graceful ways. No more muscle and nerve strain! No more figure bulges!

And you'll get more enjoyment—and more *good*—from your off-duty hours because you will be free of the "tired back" and nervous exhaustion that used to get you down.

Your Spencer Body and Breast Supports will be *individually designed*, cut and made to meet your needs—and *guaranteed* never to lose their shape.

Write or Phone for FREE Information
Mail coupon below for fascinating booklet—or phone nearest dealer in Spencer Supports (see "Spencer corsetiere", "Spencer Support Shop"). No obligation, of course!



Lordotic Posture ☐ *Breast Problems* ☐ *Ptotic Posture* ☐

SPENCER SUPPORTS (Canada) Limited, Rock Island, Quebec.

Send free booklet. I have checked my problem at left.

Name.....

Address.....

City.....Prov.....177-2-50

SPENCER *INDIVIDUALLY DESIGNED* SUPPORTS

For Abdomen, Back and Breasts

especially for them

... its citrus-like flavor and odor

hide six essential vitamins

Each tasty, 5-cc. teaspoonful of Vi-Daylin contains the minimum daily requirement of vitamin A for a child 1 to 12, twice the minimum daily requirements of vitamins C, D and thiamine, and supplemental amounts of riboflavin and nicotinamide. Vi-Daylin administers from the spoon, mixes readily with cereal, juices or baby's formula. It is stable at room temperature for two years, won't stain clothing, won't curdle milk, leaves no fishy after-odor. Children and finicky oldsters love it. Available in bottles of 90 cc., and 8 fluid ounces. Abbott Laboratories Limited, Montreal.

Abbott

VI-DAYLIN
TRADE MARK

(Homogenized Mixture of Vitamins A, D, B_1, B_2, C and Nicotinamide, Abbott)

48-52

The
CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-SIX *NUMBER TWO*

MONTREAL, FEBRUARY, 1950

Echoes from the Foothills

Average reading time — 2 min. 6 sec.

I WELCOME THIS opportunity of greeting the nurses of Canada on behalf of all the members of the Alberta Association of Registered Nurses. We extend to you our very best wishes for 1950.

It was with regret that we accepted the resignation of Miss E. Bell Rogers, our registrar for four years. 1949 commenced with a new registrar at the helm—Mrs. Clara Van Dusen. This was the first year our increased membership fee of $8.00 was in effect, made necessary by the anticipated increase in C.N.A. and I.C.N. affiliation fees which we wished to be in a position to meet and by the operating deficit of the past two years. Despite the increase in fee, our present active membership of 2,177 is the highest in the history of the association.

1949 marked the first year that associate memberships were granted, at an annual fee of one dollar. To date, our associate membership totals 871. These members are eligible to vote and become committee members and are kept informed of association activities through the A.A.R.N. *Newsletter*. The *Newsletter* featured paid advertising for the first time in the June issue and this venture has produced a revenue in eight months of over $700.

1949 marked the organization of the Banff and Jasper chapters of the association, the first two to be formed. Considerable interest and activity may soon result in similar organization in other centres.

Over a year ago, the A.A.R.N.

Goertz, Edmonton

JEAN S. CLARK

accepted with pleasure a request from the Alberta Health Survey Committee to appoint a liaison committee which would be available to discuss nursing problems. Our committee presented its recommendation in person to the Health Survey Executive and also accepted an invitation to sit with the full Survey Committee for an afternoon session on nursing.

We are gratified that a number of projects of benefit to nursing have been approved under the Dominion Health Grants. Perhaps it would be of interest to the other provinces to describe these projects briefly.

In the 1949-50 fiscal year to date, 40 nurses have been provided with assistance under the Professional Training Grant to pursue post-graduate work as follows:

Public health nursing—1st level	21
Public health nursing—2nd level	1
Teaching and supervision	6
Operating-room techniques	3
Refresher courses	3
Obstetrical nursing	2
Clinical supervision	2
Pediatric nursing	1
Hospital administration	1

In addition, funds were provided under this grant which made possible an institute on ward management and one on child guidance and development at the University of Alberta.

In the spring of 1949 an affiliation program in tuberculosis nursing was inaugurated at the Central Alberta Sanatorium, Calgary, through funds from the Tuberculosis Grant. Three schools of nursing in southern Alberta are participating in this plan.

During the fall of 1949 a program was launched to provide affiliations in psychiatric nursing at the Provincial Mental Hospital, Ponoka, through funds from the Mental Health Grant. Two schools of nursing are already sending students for affiliation.

A project under the General Public Health Grant made possible a study of nursing services in Alberta throughout the summer months. Miss Rae Chittick, past president of the C.N.A., conducted this study for the Health Survey Committee. Through the same grant, money has been made available to offer a six-weeks course in hospital administration to matrons of small hospitals. It is anticipated that this course will be offered at the University from January 30 to March 10. Money has been made available to provide teaching aids in schools of nursing and also to assist additional nursing aides to undertake the ten-month training course at the school in Calgary.

There are many more developments toward which we are working. We look forward to 1950 with optimism!

JEAN S. CLARK, M.P.H.
President, A.A.R.N.

Notice of Executive Meeting

The Executive Committee of the Canadian Nurses' Association will meet on March 9, 10 and 11, 1950, at National Office, 1411 Crescent St., Montreal.

The Scottish Board of the Royal College of Nursing reported a most successful, if rather unusual, party at which the Student Nurses' Association Unit of Leith General Hospital presented the Board's Education Department with a first-class skeleton, complete in a handsome case.

Three comments made by the examiners following one series of registered nurses' examinations in Ontario are applicable everywhere and warrant consideration:

"1. Spelling is again a source of concern. Errors were common in such words as fever, vein, doctor, skull, stomach—and more difficult words were distorted almost beyond recognition.

"2. Abbreviations were scattered throughout the papers but not quite so freely as in the previous examinations.

"3. Students seem to be increasingly aware of the importance of health teaching in their work."

—*R.N.A.O. News Bulletin*

Anesthesia

J. M. WISHART, M.D.

Average reading time — 5 min. 36 sec.

PREMEDICATION is not of great importance except in highly nervous patients and then it seldom works. Many anesthetists do not give any premedication. Atropine, however, helps to stop mucus and secretions in the mouth.

Most anesthetics now are a combination of several drugs to get the best effects of each one with none of the bad effects—i.e., spinal with pentothal; pentothal, curare and nitrous oxide or cyclopropane; local and pentothal or cyclopropane. This also results in fewer post-operative complications, less nursing care, and happier patients. Anesthetics are divided roughly into two groups—regional and general.

REGIONAL ANESTHETICS

Regional anesthesia includes local, field block, nerve block, caudal, spinal, and peridural blocks. Regional block means the interruption of the nerve reflex at the periphery. The drugs most commonly used for this purpose are procaine, pontocaine, and nupercaine. Procaine is used mainly for nerve blocks and local. It is most toxic. Pontocaine and nupercaine are used mainly for spinal and peridural blocks. Pontocaine is the least toxic in the doses in which it is used.

Barbiturate premedication will offset the convulsive tendency of all cocaine derivatives.

Apart from spinals, regional anesthesia is used only for relatively minor procedures. Spinals give maximal relaxation and complete anesthesia and so are considered by many surgeons to be the best. However, they may produce permanent nerve damage unless great care is taken in their administration.

Nursing care is limited to protecting the affected parts from burns, laceration, and pressure which the patient cannot feel. The use of very low spinals and peridural anesthesia will gain favor in obstetrical cases because they give prolonged relief from pain without the attendance of a doctor. This is particularly true of continuous peridural anesthesia which is very new, but which has been used to give anesthesia constantly for one week.

GENERAL ANESTHETICS

Substances used cause anesthesia by acting on the brain. They give relief from pain and relaxation by affecting the body as a whole.

Pentothal is a short-acting barbiturate which offers a pleasant induction, free from fear of the mask. Recovery is free from nausea and vomiting. It is given intravenously by intermittent or continuous injections. Post-operative nursing care is of short duration but very exacting as the patient may develop laryngeal spasm and cyanosis very quickly and, therefore, must be watched constantly. Treatment for such a spasm is suction and oxygen, and curare.

Curare is given intravenously and produces relaxation but no anesthesia. It acts on the junction of nerves and muscles and so permits a lighter plane of general anesthesia. The effect of curare has usually worn off before the patient returns to the ward but, if not, he may become cyanosed as the respiratory muscles may be paralyzed. Treatment is artificial respiration; 100 per cent oxygen and prostigmine, which is a specific antagonist.

Procaine may be given intravenously. It relieves pain in traumatized tissue, such as burns, operative incisions, etc. It is given post-operatively to reduce the amounts of depressing sedation, and may be used to supplement other anesthetic agents during an operation.

Ether is inhaled through a mask. It is the safest drug for inexperienced

anesthetists. Its main drawbacks are a slow unpleasant induction, post-operative nausea and vomiting. It is seldom used now, except in children, by trained anesthetists. It is the only drug which safely relaxes the uterus for versions, etc.

Chloroform is also inhaled. It is little used due to the danger of liver damage. Induction is pleasant and there is less post-operative nausea and vomiting.

Cyclopropane is inhaled but due to its cost there must be a closed circuit gas machine. It is used only by trained anesthetists due to the danger of cardiac or respiratory arrest. Static electricity causes fatal explosions so woollen blankets must be kept away from the patient's mouth and nose. Cyclopropane is usually used with pentothal and curare in combined anesthesia.

Cyclo shock is the result of a building up of carbon dioxide in the respiratory and blood system. Treatment of this condition is with vasopressors, oxygen, but not external heat. Post-cyclo cerebral irritation may occur in which the patient is irrational due to cerebral anoxia and excess of carbon dioxide. Treatment is morphine and oxygen.

Nitrous oxide is a weak inhalation type of anesthetic. It is used in obstetrics to ease early pains. It is also used extensively as an adjunct to pentothal to intensify and prolong its action.

Vinethene and ethyl chloride are used mainly as an induction for open ether. They are given via the open mask.

Recovery Room

This special accommodation is essential to handle post-operative patients until they are fully recovered from the anesthetic. It should be equipped to handle any emergency and the nurse in charge must be trained and authorized to carry out emergency treatment.

Transportation

Those in charge of transporting the unconscious patient must maintain an adequate airway and be gentle. After all nose and throat operations the patient should be in the Sims's position in transit and then the semi-prone in bed. After all other operations, the patient should be placed in the Sims's position.

Pre-Anesthetic Preparation

E. Barnett

Average reading time — 2 min. 6 sec.

On admission to hospital, a patient anticipating an operation is usually apprehensive and emotionally upset. Fear predisposes to shock and may make the administration of the anesthetic difficult. The nurse can do much to allay the dismay by building up the patient's confidence in the doctors and hospital personnel. She makes a personal contribution by her own quiet, interested manner. It is a great moment in the patient's life and the nurse should recognize it as such. At this time, she should endeavor to assist him to utilize all his religious resources. It is good psychology to explain to the patient just what will be his own part in his ultimate recovery and to stress the importance of patience and co-operation to ensure a successful start and outcome to the operation.

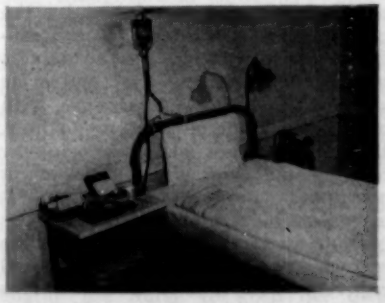
The physical preparation would include signature of consent, ade-

Miss Barnett is a member of the nursing staff at St. Joseph's Hospital, Peterborough, Ont.

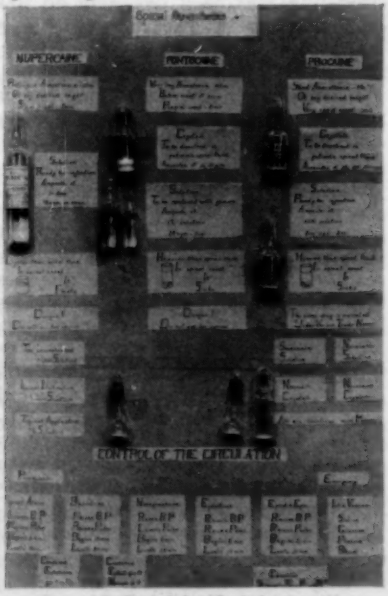
All photos by The Roy Studio, Peterborough, Ont.

Trays (left to right)—*Back row:* (a) Inhalation—open method. (b) Intratracheal. (c) Local. *Front row:* (a) Intravenous. (b) Emergency drugs.

quate fluid balance, a good night's sleep, laboratory investigations, and attention to cleanliness of the skin and alimentary tract. It is important that facial cosmetics and nail-polish are removed in order that the anesthetist may detect any deviations from the natural color of the skin or finger nails. The immediate preparation would include the local preparation of the operative area, catheterization as ordered, premedication given at the specified time, anesthetic cap, stockings, gown and identification card put on, and jewellery and artificial dentures removed. The patient is now ready for transfer to the operating-room.



The anesthetic bed



Enlarged detail of chart

A Co-Operative Venture

Progress in medical education would be without benefit to man and his various ills if there were no progress in nursing education. Newer methods in treatment require to be reviewed constantly by the nursing profession. Particularly is this true in psychiatry where most progress in the treatment of patients has been achieved during the period of greatest scarcity of nurses. Nurse educators will have to put forth greater efforts to catch up in numbers of nursing personnel and to provide instructors well versed in newer methods of training. Some provinces of Canada and states of the U.S.A. require affiliation with psychiatric hospitals at an undergraduate level. These provinces and states lack sufficient supervising nurse instructors in psychiatry. A decision of the University of Western Ontario School of Nursing to take up nurse instruction and nurse supervision in this field is, therefore, of prime importance at this time.

The Treatment Services of the Department of Veterans Affairs is pleased to co-operate with the University and to provide more hospital and clinical facilities for the training of psychiatric instructors and supervisors. This is further evidence of liaison between the universities and the Department of Veterans Affairs and will provide benefits to both students and the patients alike. The patients will obviously benefit from having the more efficient care of our trained nurses. The nurses will be able to undertake psychiatric work at a higher level and also learn to adjust to personal needs and problems better by the training they have received.

W. P. WARNER, M.B.
Director General of Treatment Services

Some Concepts of Psychiatric Nursing

E. S. GODDARD, M.D.

Average reading time — 4 min. 48 sec.

FOR MORE YEARS than we care to count, physicians and nurses treated diseases and left the patient to recover by himself. While it is readily agreed that most illnesses are self-limiting, some real strides have been made in reducing the length of the patient's stay in hospital. Newer drugs, anti-biotics, and biological preparations have lowered the mortality rate of numerous illnesses which were previously considered fatal. Physical medicine with physiotherapy and occupational therapy have further reduced the patient's hospital stay. The final challenge remains to be taken up; that is, the treatment of the individual as a sick person, and the avoidance of separation of mind-body.

Man is a complex, highly integrated organism as shown by the physiological functioning of the central nervous system, the autonomic nervous system and the endocrine system. If sickness intervenes with his way of life he gets sick as a whole. He must also get well as a whole or retain some evidence of physical or emotional trauma. In addition, it is reasonable to expect that if the patient is given an opportunity to recover as a complete individual recovery will take less time. This makes imperative the consideration

Dr. Goddard is director of psychiatry at Westminster Hospital, London, Ont.

of the emotional aspects as an integral part of treatment. The most fortunate patients are those free from worries and fears; the patient who can relax and is calm and composed has a greater chance for recovery. That desirable state may come from the patient himself, from his outlook or philosophy of life. It can be fostered by the hope and confidence of the nurse.

A good working relationship between patient, nurse and physician is of the utmost importance in medicine and surgery. In psychiatry this relationship reaches its greatest height. Here nursing in the field of human behavior becomes a challenge for tact, kindness, human understanding, keenness of observation and clarity of description. The nurse has every reason to apply the principles of science, psychology and sociology to actual clinical situations. She must be well prepared from the standpoint of information, skill and attitudes to use these concepts in psychiatric nursing.

A background of experience, self-knowledge, and self-discipline is required of the nurse in order to cope adequately with the emotional problems of others. This implies emotional maturity and adequate adjustment in personal problems of living. Emotional maturity enables her to make decisions and accept responsibility. It enables her to be adaptable in work that calls for continual changes in attitudes, in meeting patients with complex moods and set patterns. Adaptability carries with it an equanimity that enables her to keep her own thoughts and emotions in proper balance.

Another requirement is the ability to meet effectively the patient's needs. In order to understand a little of the patient's inner turmoil, some discernment of the patient's feelings and needs is necessary. Understanding the patient is the first step in obtaining his confidence; satisfactory interpersonal relationships are impossible until this is attained. Possession of discernment or wisdom will enable the nurse to keep her own thoughts and feeling states in balance and give her stability and perspective. An objective and tolerant attitude is invaluable and will assist the nurse in projecting herself into the patient's problems and will enable her to understand them. The patient is entitled to his emotional outbursts as they are characteristic responses in disturbed thinking. Lack of reasoning and judgment on the part of the nurse will do considerable damage and cause the loss of essential contact and rapport.

Every effort should be made to establish a relationship with the patient. This can best be done by anticipating his needs and satisfying them. These include adjustment to environment, knowledge of his habits, stimulation of wholesome reactions, attention to trifles, searching for interests and planning conversations or activities. By knowing the patient, his needs can be anticipated and at the same time satisfied.

As the patient's various needs are anticipated and satisfied, a question in meeting the different patients' problems develops. Disturbed, boisterous or otherwise difficult patients can be managed with tact and positive suggestion. Each new situation constitutes a challenge to be met and not a situation to be avoided. At the same time one learns to measure successes and apply them at a later date. From a growing fund of experience, handling the patient's problems consists of more than telling him what to do. There are certain periods where compromise is an important adjustment although sometimes a difficult one for the nurse. In any service where routine is defined, details clarified and simplified, it is easier for the nurse to insist on regularity than to subordinate herself to the patient's way. Co-operation and reciprocity are just as important for the nurse as for the patient and often mean the difference between contentment and contention. Compromise is a willingness to see with long-range vision, that which is in the patient's interest. Manipulation of the routines around the patient

and improvisation if needed will produce techniques which will show a tendency to accelerate recovery. In essence, psychiatric nursing is an intelligent approach built around inductive reasoning and tolerance.

The above concepts, however, should not be reserved for psychiatric nursing alone. They are applicable to all branches of nursing, since it has been amply demonstrated that there can be no physical illness without mental and emotional disturbances. The frightened child in a hospital ward, the seriously ill postoperative patient, the bedfast chronic invalid, or the accident victim who is not sure if he will walk again, all require more than mechanical performance of routine nursing duties. There is no substitute for kindness, consideration, promptness in response, alertness, the inspiring of hope and confidence.

Nursing is truly a social science operating in the field of human behavior. Where else can such rewards in terms of contentment, tranquility, relief from tension and freedom from fear be obtained for such a small amount of tact, kindness, patience and understanding?

Adventure in Nursing

MIMA M. MACLAREN *and* EDITH M. MCDOWELL

Average reading time — 6 min. 24 sec.

AT WHAT point may the nurse consider herself the finished product? Directed to any nurse, this question is invariably answered with a smile of amusement. No nurse today would have the temerity to suggest that she could ever know all there is to know about nursing. Special fields are too numerous, changes in method and treatment too rapid to permit any illusions on that score.

Yet have the fundamental needs of patients changed? Will they ever change? Will the patient eventually come to view himself as a statistic? Will his illness, for him, ever cease to be of paramount importance? Surely this is asking too much of human personality! It would seem that to understand what is happening to him will always be of primary importance to the patient; that his need to work with those who seek to help him toward his greatest possible recovery will always be present. To achieve this he may always need to be helped to discover or rediscover goals in living.

Nursing has always stood in direct relationship to these intangible aspects of patient need. The nurse today seems to have lost ground in this respect because of two factors.

Her need to be well-informed and skilled in the increasingly specialized techniques of treatment.

Her inability to keep pace with an increasing body of knowledge with respect to human personality.

Perhaps the greatest unmet need expressed by the general practitioner of nursing in considering shortages in her basic preparation lies in the area of understanding human behavior and the relationship of mind and body in health and disease. It is significant, but no cause for reassurance, that this criticism is not characteristic of nursing alone, but is held in common with other professions which seek to help people.

Fortunately the nursing profession has unchallenged access to the experience field. It is within that field that nursing education may find the

Miss MacLaren directs the nursing service at Westminster Veterans' Hospital, London, and Miss McDowell is dean of the School of Nursing, University of Western Ontario, also in London.

means of overcoming the present impasse. The busy and overburdened administrator of nursing service is aware of the problem but finds herself unable to stem the tide. The nurse-educator, too, sees the problem, and recognizes how ineffectual subject matter may be if significant relationships are not found in the experience field. When these two people find the means of facing the problem together they are enabled to plan hopefully for the attainment of a possible solution.

The University of Western Ontario School of Nursing and the Westminster Veterans' Hospital, London, for more than a year have been actively concerned with working out a plan whereby the facilities of the hospital might be used to the fullest extent by graduate nurses desirous of securing further guided study and experience. We have been fortunate in having the support and interest of the W. K. Kellogg Foundation in working through this project. Its grant to the School made it possible to provide for the training of teaching personnel and in-service education. In the light of shortages in preparation expressed by many graduates it was logical to look to the psychiatric field as the first point of departure. After examining its potentialities it seemed to us that the psychiatric hospital had developed certain traits in patient care which are not as readily discerned in the general clinical field. Some of these may be cited here:

1. The nurse in the psychiatric field finds it necessary to function as a member of a team, and to discover the nature of her role in that relationship, as well as the role of co-ordinator of the contributions of other professional workers.

2. The nurse becomes aware in this field that she is primarily concerned with group work.

3. The nurse discovers that the emphasis is placed upon the patient and his constructive resources, because these determine the probability of his favorable response to such treatments as insulin and electric shock, sub-insulin therapy and psychotherapy. Thus she is provided with an opportunity to re-evaluate the relationship between manual nursing techniques and procedures and the intangibles of patient care.

4. The nurse discovers that an increasingly large percentage of mentally ill patients recover. Therefore, the plan of patient care must provide for rehabilitation.

5. The nurse discovers that she, herself, is not a catalyst in the nurse-patient situation. A growing understanding of herself as a person accompanies an awareness of the fact that the introduction of her own personality into the situation of mental illness may have either a positive or negative value to the patient's recovery.

The educational program in the psychiatric field must make the most of these traits and, in addition, plan to provide for certain favorable conditions for the student. The following principles form the base upon which we hope to build the student's learning experience:

1. All administrative, supervisory and teaching personnel must have an awareness of the student's need for sympathetic guidance in making the essential re-adjustment to the new field, so that traumatic results may be avoided, and professional development may be assured.

2. In her professional adjustment and guidance in acceptance of the basic concepts underlying good psychiatric care, one must come to terms with the matter of time, since guidance through experience spells professional growth, in contrast with the acquisition of mere factual material. This places a limit upon the number of hours per day to be spent in the clinical field, calls for the use of the patient-assignment method, and relief from the burdensome pressures of too much work to be done.

3. Individual reading, seminars, individual and group conferences, all in relation to the student's experience in patient-assignment, must be provided within the working day. Without these, the experience may lose its value—indeed, it may result in miseducating the student.

4. There must be a desirable ratio of field-guides to students, in order that

individual and group guidance may be possible, and field experience yield its maximum of constructive educational value.

5. The students' own health and energy must be safeguarded from a too-great "service load" which would render a satisfactory educational program impossible, but assurance should be given that their contribution to patient care has positive value.

6. Provision should be made for pleasant living arrangements, comfortable home-like residence, good meals, attractively served, with provision for recreation and hobbies.

7. The surrounding social climate must be created by all professional workers in the agency, and should give evidence that it has been worked out co-operatively in relation to the principles which they profess to have given acceptance.

8. Lectures and libraries, for the provision of sound knowledge have their place, but should sub-serve the educational aims to be achieved. "... true and lasting learning is not a matter of isolated, functionless 'study,' but is the outcome of a living participation in investigation and research prompted by need and stimulated by interest in a job worth doing."[1]

REFERENCE

1. Mearns, Hughes. The Creative Adult. Self Education in the Art of Living. 1940. Doubleday, Doran & Co. Inc., New York.

EXPERIENCE IN PSYCHIATRIC NURSING

The University of Western Ontario School of Nursing, in co-operation with **Westminster Veterans' Hospital, London,** and other community agencies, will offer to Graduate Registered Nurses a programme of study and guided experience in **Psychiatric Nursing,** to commence ***on March 1, 1950.***

For further particulars write to:

The Dean, University of Western Ontario School of Nursing
London, Ont.

Increased Birth-Rate

The recent upsurge in the birth-rate among women past the prime of reproductive life is attributable, in large part, to the high level of economic prosperity and to the desire of many women to bear the children they felt they could not afford to have during the depression. Another factor has been the increase in the proportion of married women at the later child-bearing ages. Still another point, often overlooked, is the marked progress which has been made in safeguarding maternity. It is likely that older women, and particularly those bearing their first child, have been encouraged to undertake child-bearing by the reduction in the hazards of maternity. The maternal mortality at ages 35 to 39 has dropped 65 per cent between 1940 and 1947. Among women in their early 40's the rate has been cut in half, and even at the ages past 45 the reduction has amounted to about 35 per cent.

—*M.L.I.C. Statistical Bulletin*

There is a breadth of life as well as length, and there is no area in a straight line.

—IRVING FISHER

Nursing Service 1950

FLORENCE H. M. EMORY

Average reading time — 7 min. 12 sec.

IN APPROACHING A TOPIC of this nature there is one possible advantage in having attained professional maturity, namely, that experience over many years makes possible a comparison of the situation 30-35 years ago with that of today. Hence, through a comparison of that which was with that which is, it is possible to contrast the past and the present with that which should be and thus to determine the nature of the challenge which confronts us today as professional workers. Let us glance at nursing services in, say, 1912-1915.

THE PAST

Looking back upon the first decades of this century one is conscious of the fact that community health service as a whole was in the earliest stages of its development. Emphasis was given to cleaning up the environment through the application of sanitary measures destined to improve the general living conditions of the population; new health knowledge, released gradually through scientific discovery, had little effect upon community life.

These years were characterized by much illness and many deaths from preventable causes. Typhoid fever, for instance, was rampant in the fall of the year with ward after ward in many of our hospitals given over to the care of patients with this disease. It is recalled that their nursing care was an exacting discipline. The incidence of tuberculosis and deaths from it took a heavy toll also. Because of limited sanatorium facilities many of these patients were cared for in a tent in the backyard until such time as a hospital bed became available. Diphtheria, too, cut short the lives of many infants and children; oftentimes, in a choking condition, they were admitted for hospital care too late to be effective. In those years scores of infants died from intestinal causes, particularly in the late summer and early fall. Many of them were taken to hospital in a weakened condition without hope of recovery. Moreover, in a period before the full value of prenatal care was realized, too many mothers were lost at childbirth. One could go on giving further emphasis to the general situation but enough has been said to show that unnecessary illness and deaths were a common occurrence in the Canadian community.

Miss Emory is associate director and associate professor at the University of Toronto School of Nursing.

A GROWING SENSE OF RESPONSIBILITY

Glancing at community health machinery during this period there can be sensed an increasing responsibility on the part of governments for these conditions and for their prevention. On the municipal level many communities were appointing a full-time medical officer of health whose initial work emphasized the cleaning up of the environment. This was the period of the purification of water, of the pasteurization of milk, of "swat the fly" campaigns. The public health administrator, in presenting his budget to the city council, would say, "You can get the health you pay for . . . there will be fewer babies in coffins if the estimates are passed." Provincial governments were also taking initial steps which at a later date would result in more health care for the rural community. This era pre-dated the establishment of a federal department of health so that governmental interest and a resultant expenditure of funds was confined largely to the local municipality. Such expenditure was, indeed, small, by far the greater proportion of the medical dollar being spent on illness.

But with all of this the era of health education was emerging with some nurses already employed by municipal departments of health and visiting nurses engaged in a morbidity service in many centres. Special preparation for the task given the nurse in this setting was not offered in Canada, the basic course of the hospital school providing the only training available.

Hospital Services Developing

Both the in-patient and out-patient departments of our hospitals were developing and rendering yoeman service but the nursing schools attached to the hospitals lacked standards concerning inspection, curriculum guide, prepared instructors, supervisors and head nurses, and registration examinations.

It should be re-emphasized that at this time post-graduate and basic courses in nursing were not offered by our universities. Certain nurses, wishing to gain further preparation, were obliged to enrol in newly organized one-year courses in the United States.

Attitudes

Great emphasis was placed upon curative service and a wide gap in both thinking and action existed between the curative and preventive fields. In fact, in these earlier days there was no general acceptance of the true value of prevention. A nurse, for instance, entering a hospital school in order to gain the preparation necessary for the practice of preventive nursing, maintaining that interest throughout, and upon graduation undertaking health department work, was considered by her classmates to be novel, if not a bit queer. In the organized profession it was the era of sections, of a tendency to separate into groups in terms of a specialty or special interest. Programs were so arranged that much discussion took place in section meetings, with few sessions when common problems were considered by all.

Those associated with the early development of community health work remember the fear of most people for the hospital. Much persuasion was necessary in order to convince the laity of the value of hospitalization. In fact, prevention in the fields of both medicine and nursing was a new emphasis; the health ideal a new concept. Hence, the need for interpretation, for salesmanship in order that the public might be convinced of the value of health activities and thus provide increasing funds for their support. Briefly stated these were some of the factors influencing the nursing services of this period.

The Present

And now let us examine certain aspects of nursing service today. In all fairness to the situation, it must be stated that, compared with the earlier period, there is much evidence of growth with much room for encouragement.

The Expansion of Health Services

Perhaps at once the most obvious and the healthiest factor in the current situation is the overwhelming demand from the public for full-time health services in both urban and rural areas. In fact, the initial effort of the pioneer has been rewarded so that current expansion is limited largely by the lack of trained workers to undertake the task. Moreover there is a marked increase in the use of hospital facilities. Prepayment plans have increased the demand for hospital beds to such an extent that the average stay in hospital is shortened with post-hospital care in the community greatly expanded. A natural concomitant of this growth has been the increased pressure upon nurses to meet the challenge of an ever-widening range of activities. This constitutes a considerable factor in the present shortage of nursing personnel. Along with all of this, and a matter which is influencing present practice more than is realized, is a growing recognition of the interrelationship of the preventive and the curative in medicine and in nursing. The progressive concept is that

of health restoration, health protection, and health promotion: a concept of continuity of service within and without the hospital and of unified effort in promoting the community's health service; a concept not of different fields and different goals but of one field and one goal with differing emphases in reaching it. Associated with this there has come a renewed emphasis upon the economic and social aspects of medicine, with appropriate repercussions in both the medical and nursing fields.

Improvement in Preparation for Service

It is unnecessary to go far afield in order to be convinced that there has been much development in this area. The Nurse Registration Acts of the several provinces laid the foundation for the setting of standards for both education and practice. Nor is this all. There has been remarkable progress in the establishment and growth of education for nurses within the university. Port-graduate and undergraduate courses are offered in many of them and at least a portion of this work reveals an honest effort to place nursing education on a sound professional basis. Moreover, from governmental and private sources, there is considerable financial aid for those wishing to undertake such courses through scholarships and bursaries available in increasing numbers and amounts.

Along with all of this can be felt the stimulating and co-ordinating influence of the organized profession within our own boundaries. The Canadian Nurses' Association is affording the type of leadership which emphasizes the similarities rather than the differences in the various fields of nursing, striving constantly to bring into relief the common interests of all nurses. Thus there is more understanding and practice of co-ordinated effort. There is an increasing awareness, too, that a shortage in professional nurse-power can and must be supplemented by the contribution of the auxiliary worker. To this end the organized profession has sanctioned and influenced the preparation and practice of this group. But not alone the auxiliary worker has received attention. The demonstration school in Windsor, under the egis of the organized profession, is testimony at once to the fact of changing needs in meeting professional demands in service, and to the method of experimentation in determining how best those needs can be met. There is much evidence, therefore, of a fuller realization of the demand for well-equipped workers at various levels and for women capable of giving the type of leadership in administrative and teaching posts commensurate with that offered by other professions.

Increased Financial Support

Underlying and underlining all of this effort is the financial assistance in the form of health grants offered by the Federal Department of National Health and Welfare in implementing step by step a comprehensive health program for Canada. Already the stimulus of this money, administered through provincial governments, is felt in furthering nursing service and nursing education. Surely a new day for nursing is dawning when the evening newspaper of a great Canadian city could, in its editorial column, make the following comment: "A public training program for nurses would appear to be one of the key measures to ensure the success of the national health plan."

Change in the International Outlook

Those who are sensitive to changes of thought and attitude have been quick to sense development in countries beyond our own borders and outside the North American continent. Much progress has taken place in a solution of similar problems with varying degrees of accomplishment. In the field of health services England is in the forefront with perhaps the the most inclusive plan for community health ever attempted. As for preparation for nursing, the pioneer efforts of certain European countries

have afforded inspiration for the establishment of the education of nurses on a sound educational basis through the instrument of a nursing school administered and financed quite independently of the hospital. Of this Finland is a notable example.

Further, there is ample evidence that the organized profession in its international relationships is on the march. Witness the eagerness with which countries seek to qualify for membership in the International Council of Nurses. The influence of this organization in raising the standards of nursing in affiliated countries is conceded. More than formerly, too, the Council realizes the need for unified, co-ordinated effort. This is seen in the current effort of committee chairmen to seek, jointly, information desired for the carrying on of their work through the preparation of a composite questionnaire to be sent to all national associations. The action of the recent conference in Stockholm, through which the Florence Nightingale International Foundation has come within the overall administration of the International Council of Nurses, will result in co-ordinated effort in nursing education and make possible the preparation of leaders, as well as the development of research inherent in professional growth.

Still another source of encouragement lies in a relationship between the World Health Organization and the International Council of Nurses whereby advice is sought from the professional group in nursing matters. A will to meet changing conditions in a new and better way was an outstanding feature of the meetings of the Council in Stockholm. There was evident an open-minded approach to problems, with an emphasis upon the value of experimentation in their solution.

The Challenge

Finally, we come to grips with the heart of this paper—that is, with integrity and courage to attempt to determine what is the challenge confronting nursing in the year 1950. As an aid to our thinking let me raise certain pertinent questions:

1. Do we who are members of the profession really believe in nursing as an essential community service—a social utility?
2. Are we convinced that professional nursing is a significant part of the total nursing picture but not the whole picture?
3. Do we hold the belief that professional nursing requires workers whose performance will compare favorably with that of other professional groups?
4. Are we willing to try new methods, devise new plans, support new projects which purpose to meet the need in a fuller, better way?
5. Are we willing to follow the path along which scientific study will lead, that is, with an open mind and an undaunted spirit to seek what is best and, having found it, to conserve that best?
6. Are we ready to struggle, to strive, to sacrifice for professional truth and to accept the consequences of finding the truth. It will mean professional adjustment and change accompanied by professional discomfort. For it is impossible to be professionally comfortable in a period so characterized by change. Are we willing to accept professional discomfort in order that the *community and its people may be comforted?*

What then is the challenge? We have looked briefly at the past and the present. We have asked some pertinent questions concerning professional attitudes and the future. The challenge is clear. Through conviction and well directed effort we must narrow the gap between what we have and what we need; between what we know and what we do so that the public may be given the fullest and the richest service of which we are capable. The challenge is epitomized in three quotations:

From Greek literature—"Nothing is permanent except change."

The writings of Mr. Justice Holmes—"Certainty is illusion and repose is not the destiny of man."

Mark Twain—"Loyalty to petrified opinion never yet broke a bond or freed a human soul."

Construction of Hospitals

BIANCA BEYER

Average reading time — 17 min. 36 sec.

IT IS A pleasure and a responsibility to present the views of a nurse in regard to hospitals. It is a personal viewpoint based on my experience within hospitals, on observation of hospitals in other countries, and on the opportunity I have had within recent years to assist in converting a school building into a 130-bed hospital for the care of the chronically ill.

CONSULTING A NURSE

If I were asked to name one aim it would be to encourage architects to include a nurse in the consultations held prior to the planning of any hospital. The experienced nurse thinks in terms of the individuals and activities within the building and her advice would be invaluable in building or reconverting a hospital. Such advice should not be overlooked or ignored. Hospitals exist, primarily, to serve patients and their needs deserve the first consideration. However, it is the nursing staff that is responsible for service to patients 24 hours a day and 365 days of the year. Therefore, the needs and comforts of the nurses in the working situation must also receive due consideration if the patients in turn are to receive satisfactory attention and care. The same is true of all other workers in a hospital where combined effort results in satisfaction or dissatisfaction.

I have had an opportunity to nurse in a large teaching hospital, in old remodelled and new buildings, and in all services. For one of these years, 1938-39, I was granted leave of absence to complete a post-graduate course in nursing administration at the University of London in England. The course included visits of observation to hospitals in London and on the Continent—in Belgium, Germany, Poland, Latvia, Finland, Sweden, and Denmark. At this time my chief interest was in nurse education rather than hospital administration and, therefore, the nursing school rather than the hospital building was my main concern, but general impressions of the hospitals were also noted. In January, 1944, I was appointed superintendent of a hospital that did not even exist. The Civic Administration, to meet the need for additional accommodation for chronically ill patients, had decided to convert a school into a hospital and the architect had requested that a nurse be appointed to assist with the plans. This was my introduction to blueprints and to a situation where a nurse's opinions had been sought and were welcomed. The opportunity, which was presented to co-operate in an effort to produce a hospital that would be satisfactory to patients and staff, was a challenge and a privilege. I certainly learned a tremendous amount from the architect and he may have learned something about a nurse in the hospital situation from me.

UNSATISFACTORY FEATURES

A strong impression gained during my years in a large general hospital was how unsatisfactory the lay-out of a hospital can be from a nurse's point of view. I refer mainly to the oldest parts of the building and particularly to the large public wards when I cite a few of the unsatisfactory features:

1. The great distances between the patients and the service sections of the wards—namely, the utility rooms, the pantries, the linen rooms, offices and storage areas, and, therefore, the great distances for the staff to walk, resulting in wastage of time and effort.

2. The inadequacy of the utility rooms without bed-pan sterilizers and storage cupboards, with some shelves too high for

Miss Beyer is superintendent of the Runnymede Hospital in Toronto.

the nurses' use, and an absence of shelves beside sinks and sterilizers where they were most needed.

3. The lack of running water in the wards.

4. The placing of beds with the heads to the windows.

5. The unsatisfactory lighting and placing of electrical outlets.

6. The absence of cubicle curtain screening and privacy for patients.

In contrast to the old large wards there was also a new private patients' pavilion where the contrast between bare necessities and luxury was particularly striking, emphasizing anew the distinction between the poor and the rich. It is my belief, as a nurse and as an individual, that hospitals should be planned to provide care of equal quality to poor and rich alike. My observations in England and on the Continent only served to strengthen this belief where it was more commonly accepted and applied.

European Observations

In England I had a very good opportunity to observe the pavilion types of hospitals and to realize my preference for the block style of architecture to conserve heat, space, and effort.

The most practical, satisfactory, and beautiful hospitals anywhere were in the Scandinavian countries, particularly in Sweden and Finland. Outstanding impressions were of spaciousness, brightness, attractiveness, thoughtfulness in planning for the comfort of patients and staff, and for the care of poor and rich alike. Rooms were large, bright, and cheery; nursing units were small to minimize walking, in patient care; equipment was of good quality and complete, planned for the care of all citizens equally, and the exteriors and surroundings of the buildings were as attractive as the interiors.

Learning Opportunity

In my capacity as superintendent of a hospital which was opened twenty months after my appointment, a real learning opportunity was presented to me during the period of preparation. Perhaps you would be interested in some of the convictions gained from this experience:

1. The first and foremost is expressed by two quotations:

(a) "Quality is not an accident. It is the result of intelligent planning."

(b) "Recollection of quality remains long after price is forgotten."

The lesson learned was that the cheaper price usually indicates poorer quality and costlier maintenance and that it pays to purchase good quality for satisfactory and lasting service.

2. That it is a grave mistake to have hospital service dependent on *one* elevator. Through bitter experience I have learned that one elevator cannot be expected to serve both for freight and passengers in the same building, particularly when the serving of meals is dependent on it, and when it is automatically controlled and, therefore, more sensitive and "temperamental."

3. That cubicle curtain screening is a necessity for patient privacy and staff satisfaction.

4. That color therapy and pleasing appointments are morale builders.

5. That an attractive exterior should be given equal consideration with a pleasing and satisfying interior.

Community Health Centre

From the foregoing general statements I should now like to transfer my thoughts to a specific situation and then to details applicable to the specific situation.

A hospital building committee should be interested in the details of hospital construction that appeal to a nurse. More and more, in the field of public health, emphasis is being placed on prevention rather than cure. Therefore I would prefer to name such a building a community health centre. The centre would include a wing for in-patients who require hospital treatment and care, as well as public health facilities and facilities for out-patients' examination and treatment, including clinics, private offices for doctors and dentists, x-ray and physiotherapy departments. We should take for granted that the health centre would

be built only after a complete and careful survey of the district's requirements had been made and its situation and type determined to meet the needs.

I will not attempt to describe the type of building this community health centre should be or how it should be constructed. Rather, I will confine my remarks to observations regarding the wing for in-patients—the hospital as we call it today. If this hospital is required to meet all the needs of the community in which it is situated, it should be planned to care for all types of patients, including medical, surgical, obstetrical, the mentally ill, the chronically ill, and those with communicable diseases. Therefore, included in its facilities must be an operating-room suite, a delivery room suite, a nursery, an isolation wing, rooms for patients and all adjunct areas required for service to patients, with the necessary accommodation for staff.

Satisfactory care of patients and ease of operation for the staff are inseparable. *Good hospital service and patient satisfaction are directly dependent on the satisfaction of staff in the working situation and in living conditions.* I cannot overemphasize the importance of this statement. So often these days one reads that graduate nurses are not willing to include menial tasks in their care of patients. I am prepared to deny such a statement and to say, with definite knowledge, that the graduate nurse is prepared to give service to patients in any form that it may be required, including the most menial tasks. However, the graduate nurse is an intelligent individual and she does object to the performance of her duties in situations and surroundings that are unsuitable, where she wastes both time and effort in the midst of unnecessary confusion, and where such conditions exist due to lack of understanding and foresighted planning.

Suggestions of Value

May I, now, make some observations that might be of value to architects in planning a building in which a nurse would find satisfaction and pleasure in nursing a patient and, therefore, one in which the patient would receive full benefit. The following factors would definitely appeal to nurses:

1. A building of fire-proof construction.
2. Suitable entrances and exits to allow for the necessary control of traffic and limited to give a feeling of security. One entrance for the general public.
3. A pleasing exterior and well planned surroundings, with delivery entrance, parking area, admitting entrance, garage and gardens suitably placed in relation to outside appearance and to the windows of the building.
4. An attractive entrance lobby that offers the public an immediate impression of cleanliness, order, and friendliness. Ample and comfortable waiting-rooms, cloakrooms, and washrooms for visitors. Well placed information desk and public telephone. Well placed and attractive direction signs.
5. Concealed wiring and plumbing.
6. Acoustic treatment of ceilings in service areas.
7. Wide corridors and stairways, possibly 12 ft.
8. Wide doorways suitably protected by metal edging, to allow for ease in moving beds and conveyors, possibly 4 ft.
9. High ceilings and a good system of ventilation—12 ft.
10. Large low windows which can be cleaned from the inside, with picture windows wherever possible.
11. Good and adequate lighting, indirect wherever possible, with fixtures which are easy to clean, without ceiling lights in patients' rooms and with night lights.
12. A satisfactory heating system.
13. At least two elevators.
14. A dumb-waiter from the central supply room.
15. A soiled linen chute leading directly to pick-up carts.
16. A vacuum-controlled chute for the shaking of mops.
17. Floors of terrazzo or tile with a curved base and a raised ledge to prevent the scraping of walls by furniture and

conveyors. In corridors, a central strip of linoleum, for ease of walking, chosen to blend with the color scheme in the area.

18. Terrazzo blocks or colored tiles on walls of all service rooms, such as kitchens, pantries, bathrooms, utility rooms, cleaners' rooms, etc., to a height of 4 to 6 ft., depending on fixtures and height of ceiling.

19. Muroleum or other protective, washable material on the walls of corridors, offices, patients' rooms, day rooms, dining-rooms, etc., to a height of 3 to 5 ft.

20. The application of color therapy throughout the entire building, planned to suit the situation and the functions in the area. Color therapy improves patient welfare, staff morale, and public goodwill.

21. Adequate storage space for supplies that must be stored in preparation for the work that must be done, with suitable accessories to encourage cleanliness and order.

22. Storage space for wheel-chairs and stretchers.

23. Stainless steel sinks, tables, shelves, and equipment wherever possible, for cleanliness, ease of maintenance, good appearance, and endurance.

24. Rounded or slanting surfaces for ease in maintaining cleanliness.

25. Solariums.

Concentrating now on the patients' units, I would consider the following factors to be of importance in patient care:

1. Single, 2-bed and 4-bed rooms.

2. The number of single rooms, 2- or 4-bed rooms would be dependent on the type of service to be rendered, e.g.: *Single rooms* for: private patients, seriously ill or noisy patients, isolated patients. *2-bed rooms* for: semi-private patients, convalescent patients. *4-bed rooms* for: less expensive accommodation.

3. In all rooms beds should be placed parallel to the exterior walls.

4. Each bed should have at least 80 sq. ft. floor space and for each patient there should be: a clothes' closet, call light, double utility outlet, bed light or shaded wall light.

5. Each room should have running water to allow the medical and nursing staff to maintain good technique. Rooms for private patients should have accommodation which provides for emptying, flushing, and cleansing of the patient's individual bed-pan and with a bed-pan holder or cabinet. Rooms for isolated patients would require similar toilet accommodation and a sub-utility room, possibly between two units. For isolated patients there would be required, also, a separate pantry with adequate facilities for sterilization of trays and china. Less expensive accommodation—a 4-bed room—might be arranged with a toilet room and sub-utility room between two rooms, thereby lessening the nurse's steps.

I fully realize that additional plumbing and fixtures increase initial costs but they are essential for good service, to satisfy patients and staff, to maintain cleanliness and to prevent cross-contamination. These reasons are more important than cost.

6. Furniture and equipment should be similar for all patients, the need based on the need of the sick person, not on the amount the person is able to pay. Therefore, essential equipment such as beds, bedside tables, over-bed tables, and chairs should be standardized. If desirable in certain rooms, unnecessary but attractive items such as rugs, floor lamps, and easy chairs may be added.

7. Service areas should be centrally located, well planned to meet the requirements of the particular unit, and well placed to eliminate unnecessary walking. By service areas, I refer to:

Nurses' stations or charting desk room. Medicine cabinet room with sink and running water and with adequate and suitable storage space for drugs and narcotics. Nurses' workroom with sterilizers, work table, and storage cupboards. Unit pantry for preparation of nourishments. Linen rooms. Flower rooms. Cleaners' closet, suitably ventilated and equipped.

8. Centrally located dietary department for: preparation of meals, setting of trays, washing and sterilizing dishes.

The advantages of centralization are: Concentration of equipment and staff with necessary supervision; standardization of service; removal of noise from patients' areas.

Electrically heated conveyors should be used for serving meals and each tray should be served individually. Only in this way can hot foods be served hot and individual consideration given, resulting in the patient's enjoyment and appreciation. The sick person's appetite needs to be tempted and all of us are creatures of habit in our likes or dislikes for certain foods. Meals, quite definitely, retard or hasten recovery and, therefore, must be given primary consideration in patient care.

I have spoken in general terms about certain factors in hospital construction that would appeal to me, and I have been more specific in regard to the preparation of the patients' accommodation to allow for satisfactory nursing care. Now, having stated previously that "good hospital service and patient satisfaction are directly dependent on satisfaction of staff in the working situation and in the living conditions," I should like to speak briefly of staff accommodation necessary to produce that satisfaction:

1. Administrative offices, including business office, spacious, bright, cheerful, with quiet surroundings and the necessary privacy for concentrated work and an incentive for good work.

2. A board room. (May be combined with superintendent's office.)

3. Cloakrooms, washrooms, and rest-room facilities, suitably equipped and furnished.

4. Lecture room, classroom or both, to meet the requirements of educational programs.

5. Locker rooms—spacious, well-lighted, well-ventilated, and suitably equipped with mirrors, benches, and adjoining washrooms.

6. Cafeteria in conjunction with attractive and comfortable dining-rooms. Food is important in patient care. It is also important in producing staff satisfaction, to give staff the strength and endurance for perpetually arduous duties concerned with the care of the sick.

7. Provision for accommodating the resident medical staff including: Single bedrooms with clothes' closet and a basin with hot and cold running water; suitable bathroom with tubs, showers, wash-basins, and toilets; a sitting-room.

Accommodation should be attractively decorated and comfortably furnished and should be as distant as possible from patient accommodation, preferably in a separate wing or building.

8. Nurses' residence, including plans for:

(a) The educational department, according to the type of educational program, and based on accepted educational requirements.

(b) Recreational facilities including those for: *Open-air activity*—tennis courts, roof garden; *interior athletic activities*—recreation room, gymnasium, swimming pool; *entertainment*—drawing-room, sitting-rooms, kitchen facilities, reception rooms, public cloakrooms and washrooms.

(c) Housing accommodation, according to the need of the occupants, including single bedrooms with clothes closet and a basin with running water. Suitable bathroom with tubs, showers, wash-basins, and toilets, or single rooms with private baths or connecting baths. Suites of two or more rooms with private baths. Guest-room or rooms with private baths. Each room should have an individual key for door and closet. Community laundries, sewing-rooms, and kitchenettes. Suitable windows, flooring, wall finishes, lighting, and call systems.

(d) Necessary accessories. Health centre and infirmary. Central linen room. Janitors' and maids' closets. Storage rooms, including trunk rooms. Elevator. A direct connection with the hospital. Comfortable, suitable, and attractive furnishings.

Throughout my discourse concerning the hospital and the nurses' residence, it has been obvious that recommendations have been made without thought of cost. However, the recommendations have been based on necessities and the adjuncts which are required to produce general satisfaction and pleasure and, therefore, I offer no apologies for disregarding cost. Also, my statements have been frank and it is my hope that plain speaking will cause you to realize that a nurse does have some opinions

which may be of value in making a hospital suitable and attractive for patients, staff, and the general public.

In closing, I should like to repeat and emphasize two earlier remarks that "the hospital exist primarily to serve patients" and that "the experienced nurse thinks in terms of the individuals and activities within the building." Therefore, she bases her opinion of its suitability on the care she is able to render the patient, and on the ensuing benefit the patient receives. Only when satisfaction has been derived can it be transmitted.

REFERENCES

1. Arthur, Prof. Eric. Colour. *The Canadian Hospital*, July 1946.
2. Birren, Faber. Color and Psychotherapy. *The Modern Hospital*, Aug. 1946.
3. Davis, Graham L. What Is a General Hospital? *The Modern Hospital*, Nov. 1946.
4. Erikson, Carl A. Planning the Educational Department, Sept. 1946; Planning Space for Recreation, Oct. 1946; The Student's Room and its Auxiliaries, Nov. 1946; Accessories to the Nurses' Residence, Dec. 1946. *American Journal of Nursing*.
5. Hoge, Vane M. Planning for the Hospital-to-be. *The Modern Hospital*, Aug. 1946.
6. Hughes, H. Gordon. Designing the Modern Hospital. *The Canadian Hospital*, Dec. 1946.
7. MacEachern, Malcolm T. Hospital Organization and Management.
8. McGibony, J. R. Health Center Designed for Rural Needs. *The Modern Hospital*, Mar. 1946.

Evaluation of Schools of Nursing

FOUR YEARS AGO this month, the report of the Committee on Nursing Education, containing details relating to the proposed accreditation of schools of nursing in Canada, was published. There, the purposes of accrediting were set out as being:

1. To stimulate the improvement of nursing education by defining desirable standards for nursing schools.
2. To assist prospective nursing students in selecting nursing schools, and to supply information to vocational guidance workers in high schools.
3. To get information which would be useful in educating professional and lay groups regarding nursing education.
4. To guide the provincial associations which are responsible for the standard of nursing education in each province.

The possibilities of setting in motion a national program of accreditation were carefully studied by the Executive Committee of the Canadian Nurses' Association during the spring of 1946. It seemed a desirable project. Though the hospitals of Canada have been graded for many years by the American College of Surgeons, the relative status of individual schools of nursing has been a matter of hearsay. It was proposed that an Accrediting Committee should be set up which would evolve "standards for the evaluation of nursing education and practice" and, with these as a guide, would visit "those schools which voluntarily seek recognition and identification with this activity."

It was an ambitious proposal that would necessitate trained personnel and a considerable expenditure of time and money. Finally, the following resolution was adopted in June, 1946:

> Inasmuch as funds are limited and other projects seem to be more urgent, further action in regard to the Accrediting of Schools of Nursing be not taken at the present time.

There the matter has lain, so far as the Canadian Nurses' Association was

concerned, until the past few months. Its revitalization now is due to two main factors:

1. A program of *evaluation* of schools of nursing, as distinct from the broader project of accreditation, has been developed by the Canadian Conference of Catholic Schools of Nursing.

2. The Canadian Nurses' Association has been sponsoring the Metropolitan School of Nursing at Windsor, Ont., since January, 1948. It is recognized that this is a special venture to demonstrate the practical operation of an independently financed school of nursing. Nonetheless, the C.N.A. Executive Committee has become increasingly aware of the desirability of developing some adequate tool for the evaluation of its school.

What is an evaluation program? How does it get started? What is done with the findings? Is such a program feasible for the C.N.A.?

In his introduction to the Manual, which was prepared for the guidance of the Sister examiners, Rev. Hector L. Bertrand, S.J., director and adviser to the Canadian Conference of Catholic Schools of Nursing, reviewed the background of the program which saw seven Sister examiners visit and evaluate 24 schools of nursing in Canada. Father Bertrand wrote:

> In August, 1946, a group, composed of the Sister examiners and the members of the Canadian Conference of Catholic Schools of Nursing, met in Montreal for a period of 15 days. The purpose of this meeting was (1) to study the possibilities of evaluating our Catholic schools of nursing throughout Canada and, (2) to prepare our conference members and our examiners for this tremendous task . . . The schools (evaluated) located in 19 different cities, 8 different provinces . . . were under the direction of 19 different sisterhoods and represented a total number of 2,695 students.

So that every nurse in Canada will have an opportunity to learn the facts regarding a program of evaluation before the matter is again discussed at the C.N.A. convention, a series of short articles will appear in consecutive issues. Miss Margaret Street, convener of the subcommittee studying this matter, has prepared the article for March. Sister Denise Lefebvre of Montreal, who played an active part in the aforementioned evaluation program, will contribute the April article. They will offer suggestions as to how a similar program might be initiated by the C.N.A., building on the splendid foundation that has already been laid. By cooperative effort and understanding, it may be possible to launch a full-scale program of evaluation for all schools of nursing in Canada.

Florence Nightingale International Foundation

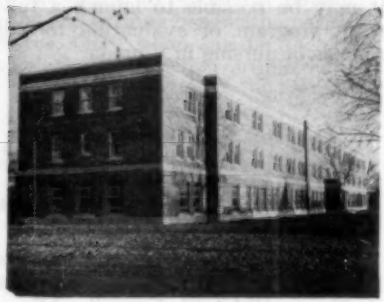
Now that the International Council of Nurses has accepted full responsibility for the Florence Nightingale International Foundation, a new committee has been set up to make plans for the future. As hitherto, the activities of the Foundation are to be of an educational nature. Its principal objectives will be to promote research, to create a centre of information on educational facilities, to establish and stimulate the award of scholarships, and to develop a section of the Library of the International Council of Nurses dedicated specifically to Florence Nightingale.

Canada will be represented on the new committee that has been named by the I.C.N. by Miss E. Kathleen Russell, director of the University of Toronto School of Nursing. The other members so far nominated include: Mrs. R. Louise McManus, director of the School of Nursing Education, Teachers College, New York; Miss Mary I. Lambie, director of the Division of Nursing in the Department of Health, Wellington, N.Z.; Miss Venny Snellman, director of nursing education, Department of Health, Helsinki, Finland; Miss Marjorie Duvillard, director of the Bon Secours School of Nursing, Geneva, Switzerland; Miss Ellen Broe, educational director, Post-graduate School, Aarhus University, Denmark. The League of Red Cross Societies has nominated Miss Yvonne Hentsch, their chief nurse, as their representative. The first meeting of this committee is to be held in London on March 1 when future plans will be drafted.

New Residence Opened

In Windsor, Ontario, on Saturday, November 26, the new building for the Demonstration School, in association with the Metropolitan Hospital, was opened at 2240 Kildare Road.

Readers will recall that as part of their contract with the Canadian Nurses' Association, the Metropolitan Hospital and the city of Windsor undertook to put up a building,



The residence

to be used for the School during the demonstration period, and that in the meantime a house would be converted so that the School might commence in January, 1948.

Last autumn the very fine new building was completed, and the formal opening arranged for the last week-end in November. On Saturday the official groups concerned were represented at the opening ceremonies in the recreation room. These were attended by representatives of the city of Windsor, the School Board, the Canadian Nurses' Association, the Canadian Red Cross Society and its Windsor branch, the Metropolitan Hospital, the Registered Nurses' Association of Ontario, the Minister of Health and Department of Health, Ontario.

The representative of the Mayor presented the golden key to Mr. J. E. Carruthers, chairman of the School Board, who responded in an extremely fine manner, taking the opportunity of emphasizing some of the fundamental principles of the School. Miss Agnes Macleod spoke, both as first vice-president of the Canadian Nurses' Association and as chairman of the Demonstration School Committee; also Col. Bishop, chairman, Central Council of Red Cross, and the Hon. Russell Kelley, Minister of Health, Ontario. A telegram of congratulation from the Hon. Paul Martin in New York was read. Following this the guests had tea in the dining-room and then were conducted over the building in groups by some of the students.

On Sunday, the building was open for inspection by the public, who flocked there in very large numbers. The building has three floors. On the ground floor are the demonstration room, two lecture rooms, two laboratories, the dining-room, kitchen, recreation room, and storerooms. The first floor has the library, reception room, and offices, as well as some living quarters for students and staff. The second floor is entirely student living

The library

quarters, including two sitting-rooms with kitchenettes and two small laundries.

The Windsor taxpayers seemed tremendously interested and pleased with what they saw; as well they might be, for the erection of this building demonstrates that they are progressive and open to new ideas and is a splendid community effort.

NETTIE D. FIDLER
Director
Metropolitan School of Nursing

Bright classrooms

Institutional Nursing

The Patient on a Bradford Frame

MARY E. PICKENS

Average reading time — 4 min. 48 sec.

THE BRADFORD frame has been used for a wide variety of orthopedic conditions so that it is probable every nurse has cared for patients on this piece of equipment. In the minds of many lay people, being subjected to a period of treatment on such a frame is practically synonymous with being strung up on the torture-rack of ancient history. Since the Bradford frame enables the nurse to care for her patient with a minimum of discomfort to him, it is well that she should understand the patient's point of view and be ready to meet it satisfactorily. Moreover, there are some special points in nursing care that should be thoroughly familiar to every nurse. These will be discussed in detail.

PSYCHOLOGICAL APPROACH

Typically, the patient who is to be placed on a Bradford frame can be sure that he is due for a fairly long period of hospitalization. The first necessity, then, is to assist him to adjust to the status of patient and still maintain a normal outlook on life. This becomes easier if he understands what is going to happen. The nurse should take the time to explain the treatment before she starts to put the patient into position. This precaution is equally important with the relatives who are so fearful of the fate of their loved one.

Other ways in which the patient will be helped to adjust more quickly to his new situation include: placing his bed near a window; arranging the lights to afford the maximum of illumination and the minimum of glare; putting him in a room with cheerful companions; moving the bed out to the sunroom whenever possible; providing him with some form of occupational therapy suitable to his capacity and position. With most older patients there is the problem of how bills are going to be paid during the period of enforced idleness. If some useful hobby can be started that will be of commercial value in the future the patient will be more co-operative in submitting to the necessary care. Provision should be made for the continued education of school-aged children that they may not suffer the loss of their term's work.

PHYSICAL FACTORS

The nurse should understand the purpose of the apparatus, why it is being used, and what it is hoped will be accomplished. She should know how the set-up should look and check the apparatus regularly to prevent contortions. Whenever possible the patient should be encouraged to help himself, after the second or third day, to prevent muscular weakness. There is no more practical way to give the patient a feeling of independence.

Good nursing care will follow when the nurse knows the various positions that afford the patient comfort. She should have a knowledge of the limitations when moving her patient. She should know how to turn him over, carefully supporting both the shoulder and pelvic girdles. Obviously, this should not be attempted by a nurse working alone. Extreme care and gentleness are essential to avoid

Miss Pickens is nursing arts instructor at the Peterborough Civic Hospital, Ont.

motion of the spine which would be accompanied by excruciating pain. It is a safe rule to follow that too much help at this time is better than too little.

Foot-drop can be an alarming complication if proper precautions are not taken. Support and exercises for the feet should be the concern of both nurse and patient. A properly adjusted foot-board is a simple remedy that can be used at the foot of the bed to support the feet and at the same time elevate the bed-clothes to eliminate the drag of their weight. Active or passive exercises may be ordered, in addition.

The diet of a patient on a Bradford frame should be adequate in calories with plenty of fluid and roughage. Usually it is high in calcium, phosphorus, vitamins A and D. The patient should be encouraged to feed himself from a table suspended over the frame. The food should be prepared in advance to facilitate easy handling—meat cut, salad shredded, etc.

The primary purpose of good personal hygiene is, of course, to promote the comfort of the patient. Equally important is the prevention of decubitus ulcers. Thus, a daily bath and adequate alcohol rubs will help to care for the skin. Properly made pads to eliminate points of pressure will increase the patient's ease and avoid undue friction on the skin.

Elimination should be regulated by diet where possible. Harsh cathartics should be avoided. When ordered by the physician, a small enema may be given. An accurate record of fluid intake and output should be kept. The nurse should keep a close watch for a possible distended bladder. Incontinence of urine should be controlled by the use of a retention catheter or by tidal irrigation.

The frame should be elevated on bases and be arranged with a divided cover so that the spine is not disturbed when the patient uses a bed-pan. Different orthopedic conditions present varied problems but the nurse should know how to place the bed-pan in position with the minimum of discomfort to the patient and the maximum of protection to the canvas on the frame and the patient. Sometimes a trapeze is provided with which the patient can help himself on the pan if the frame is not sufficiently elevated.

Traction

The application or removal of traction is the doctor's responsibility and it is only upon his direct order and explicit instructions that the nurse either applies it or makes any alteration in it once it has been applied. A special traction tray or basket, completely stocked with orthopedic requirements, simplifies the application of traction.

If traction is being used for the treatment of the patient on a Bradford frame, it is the nurse's responsibility to check it several times daily to be sure the ropes are in the pulley sockets and the weights are free. The bed-clothes should not be allowed to interfere with the ropes at any time. It is important to observe the patient during the time he is asleep to ensure that the desired posture is maintained.

The Common Cold

It is believed that the constriction of the small blood vessels supplying the nasal mucous membranes and the resultant blanching makes these membranes more susceptible to invasion of pathogenic organisms because the source of white cells and antibodies is diminished. . . . That there is a psychosomatic aspect to the development of colds is shown by the fact that exposure to cold of individuals under anxiety or emotional tension causes the blanching of the vessels to be prolonged and, therefore, they are susceptible for a longer period. In a study of a group of kindergarten children it was revealed that children of divorced parents contracted on the average a greater number of colds than did others.

The Stryker Frame

ETHEL J. FENWICK

Average reading time — 4 min. 6 sec.

THE STRYKER frame is a modified form of the well-known Bradford frame, which fits on a stand having a pivot device at each end. It was designed by Dr. Stryker of the University of Michigan Hospital orthopedic staff. The first Stryker frame was made in 1937-38. Dr. Stryker's purpose in designing this equipment was to provide a set of orthopedic frames on which the patient could be turned with ease by one nurse.

The indications for its use are: (1) Spinal injuries with paralysis. (2) Spinal operations requiring postural correction.

The complete Stryker frame includes posterior and anterior pieces, standard, frame cart, head-piece, arm supports, foot supports, overhead frame, and tray platform.

Both the anterior and posterior frames have an upper and lower canvas cover for support. The canvas covers are usually strapped in place with buckle straps to keep the canvas constantly taut. When buckles are used they must be placed with the buckles off centre to prevent pressure from them with any sagging of the covers. The upper anterior canvas should extend from just below the shoulder girdle to the symphysis pubis while the upper posterior frame will cover from the symphysis pubis to the top of the frame. The lower canvas cover on each frame should extend from 4" below the pubic bone to the internal malleolus. The 4" space mentioned is to provide for a perineal opening. After the nurse has checked the placement of the canvas and tightened the buckles she is then ready to pad and cover it.

PADDING

The padding used on Stryker frames varies with different hospitals. The padding may be cellucotton covered with gauze. These are made to fit each frame and then taped in place. Some hospitals fold a blanket above the canvas, covered with a sheet. Others use a blanket between the canvas and the straps and a proper sponge rubber mattress above the canvas. Whichever technique is used, a sheet covers the padding and passes over the edge of the frame and is pinned just under the edge of the metal frame. If separate upper and lower covers are used the perineal opening is left free on the anterior frame, and a 4" or 6" wide padded buttock strap is used for the posterior frame. A split anterior cover is most satisfactory for female patients. The buttock strap should be kept in place except when the bed-pan is being used, otherwise there will be sagging of the buttocks and poor spinal alignment.

When a set of Stryker frames is covered the nurse must be careful to see that the perineal openings on the anterior and posterior frames match exactly. Otherwise the patient will have to be moved up or down on the frame and the aim of the nursing care defeated.

The most satisfactory type of head-piece is one attached to the anterior frame. It consists of a piece of canvas with a heavy wire large enough to go around the head to give the canvas support. The canvas has an opening in the centre large enough to surround the patient's eyes, nose, and mouth. A quilted face-piece, with similar sized openings in the centre, fits inside the canvas and is much softer and more comfortable for the patient and can be changed for laundering.

The feet are supported in a normal position by a canvas covered foot support, with the heels free. This is removable.

Miss Fenwick is science instructor at the Civic Hospital, Peterborough, Ont.

A bar, running longitudinally above the patient, may be useful to him in lifting his shoulders if this is allowed.

Two wooden arm-boards fit into sockets in the runners below the frame. These, covered with pillows, support his arms when on either frame—they are not used extensively when the patient is on the anterior frame. Runners or standard are the non-movable part of the frame. The frame cart suspends the frame and makes it easy to move it.

The tray platform is a sliding board approximately four feet in length, which fits into the runners and is used for meal trays, letter writing, and other occupations when the patient is on the anterior frame.

To Turn the Patient

Remove the bed clothing; place a pillow over the legs lengthwise; remove the arm-boards, foot-board, and head pillow; place the anterior frame with the narrow end toward head of patient, the face support over the face; press the ends down over bolts and hold by tightening the wing nuts, squeezing the patient snugly between the frames.

The patient is told to wrap his arms around the anterior frame. If he is very thin or small, strap him in. The nurse may strap the patient to the lower frame and put on the upper frame. The alternative method is to put on upper frame and strap the two together. Release the stop locks at each end.

Instruct the patient as to which way you are going to turn the frame. Turn the frame quickly being careful not to jar the patient. Make sure the spring locks have snapped back into place before letting go of the frame. The posterior frame can now be removed. The foot-board and arm-board may be replaced and the bed remade.

In the prone position the patient is able to read, write, feed himself, and do occupational therapy. Intravenous and transfusion treatments may be given in either position.

The Stryker frame enables one nurse to turn the patient easily and safely. The use of this frame has saved much nursing time, has frequently eliminated the use of plaster casts, and saved the patient from much discomfort and inconvenience.

Bile Acids

The chief functions of bile are these:

1. Bile acids aid in the emulsification and absorption of fats and increase the effectiveness of the pancreatic fat-splitting enzyme lipase. They also serve to lower the surface tension of fats so that they lend themselves more readily to emulsification. Although pancreatic lipase is active in the absence of bile acids, its activity is increased approximately threefold in the presence of bile.

2. Bile acids promote the formation of bile by the liver. After aiding in digestion, 80 to 90 per cent of the bile acids are absorbed into the portal circulation and carried to the liver, where they lend themselves to resynthesis of bile by the liver.

3. Bile acids aid in the absorption of iron and calcium and are necessary to the absorption of vitamins D, E and K and of carotene, the precursor of vitamin A.

4. Bile acids aid in maintenance of normal intestinal motility. While bile acids are not primarily cathartics or laxatives, they do have an important role in the maintenance of normal peristalsis.

5. Bile acids are anti-putrefactive and inhibit excessive growth of *Escherichia coli*, but they are not to be considered as general intestinal antiseptics.

6. Bile acids prevent the precipitation of cholesterol and fatty acids in the gallbladder by holding fat acids in solution. This does not mean that bile acids will "dissolve" gallstones in the gallbladder, nor does it necessarily mean that a person with a low bile output is more susceptible to gallstone formation.

—*Journal of the American Medical Association*

Private Duty Nursing

Integration of Hospital and Community Services

SOPHIE HOLMES

Average reading time — 7 min. 12 sec.

NURSING HAS BEEN DEFINED as "a basic concept for the promotion of health, the prevention of disease, and the care and rehabilitation of the sick." The very essence of that definition illustrates the need for an understanding and complete co-ordination of the various branches of nursing. In the prevention of disease, the public health nurse, the industrial nurse, and social agencies all work together. But, since disease does attack in spite of our fight against it, the curing, or at least the easing of suffering and distress, is our aim, whether it be in the hospital or in the home. And here again the best service is given where there is complete co-operation and accord among the nursing services brought in, an intelligent conception of each person's work, and a very real respect for what each one is trying to do.

The most efficient, helpful, and time-saving centre from which these services can be drawn is through a community service agency. This is a central registry of the various branches of organized help in a community, which may be called upon for the health needs of that region. It is invaluable to those cities, towns, or districts that operate one, since it saves overlapping of services and creates a more direct means of caring for the residents. It is very important to consider the hospital as a member of such an agency and not a unit apart, for the best care cannot be given unless all these branches are correlated. The person in the home is that same person who is now the patient in the hospital, and his background with all its problems and human relationships has a great bearing on his recovery. It is being realized more and more that the psychological disturbances of the patient have far-reaching effects on his specific disease and only by knowing the whole story can helpful and wise treatment be given.

Miss Holmes is a private duty nurse in Toronto.

WORKING TOGETHER

I should like to take you to a mythical community and give you a picture of how the various branches of nursing work together, each one necessary and responsible in its contributions to the welfare of the patient.

The public health nurse has learned at the school that the doctor had to come during the night to see Betty Smith's father—it was his heart again. So the first call on her rounds is at the Smith's. Already arrangements have been made for his admission to the hospital and she reads in Mr. Smith's face his anxiety over his condition and what his inability to provide for his family now, and perhaps ever, means. She also reads apprehension of what the hospital will be like and what he will have to do. Here she is able to do one of her most helpful pieces of work for she has kept in touch with the current trends of treatment and hospital procedures. She is able to describe his setting there, whom he is likely to meet, and what his general treatment will be. She will tell him and his family the

regulations about visiting and even what articles he will find useful to take with him. This attitude of assurance, and knowing whereof she speaks, inspires confidence in the patient and has a very real therapeutic value.

Now another branch of community service is called upon. Since there is no one to leave with the youngest little girl, Mrs. Smith cannot accompany her husband to the hospital. The Red Cross transportation service of our mythical town has said they would be very glad to take him. They call for him with a comfortable car.

When the preliminaries of admission are completed, the patient is taken to the ward. The head nurse, or the nurse assigned to look after Mr. Smith, takes him to his bed and, in her intuitive understanding of his apprehension, assures him of her interest in his care.

In the meantime, the public health nurse has called the head nurse to tell her something of his situation at home. This information, necessary to her and to the doctors in assessing Mr. Smith's case, the head nurse will pass on to the social service worker or public health nurse on the hospital staff. Realizing his anxiety over financial matters, the staff social worker will get in touch with Mr. Smith's employer so that his sick benefit insurance can be paid as soon as it is due—a factor in his treatment as important as any medicine he might take.

On further examination of the patient, the doctor feels that the seriousness of his condition warrants the calling of a private duty nurse. The day period of duty seemed to give the greatest opportunities for service.

When the selected nurse comes on duty, the head nurse gives her any special information about Mr. Smith that she feels will help her in her care of him. She will see that the new nurse is oriented in her surroundings to give her assurance and confidence in herself and her ability to carry out her duties. Her intimate contact with the patient and his family is a valuable help in his recovery and an interpretive link with the hospital background.

The relationship between the head nurse and the private duty nurse is again part of that correlation so necessary to good nursing care—the private duty nurse in her interpretation of the institutional side to the patient and of the patient to the head nurse; the head nurse in her confidence and reliance in the bedside care given by the private nurse. The head nurse has the satisfaction of many contacts to complete her work picture; the private duty nurse the satisfaction of seeing health restored by her direct care.

At four o'clock, the ward nurse assumes Mr. Smith's care when the private duty nurse goes off duty. He will, of course, have only a share of her time, divided as it is among the patients assigned to her. In her contacts and care of her patients, the ward nurse learns one of the great lessons in psychology and human relationships, if she perceives them always as individuals and not just as number such-and-such on the treatment card. If Mr. Jones is cross with her, it is probably some worry his wife brought him from home. She gives an extra word of cheer to Mr. Brown because he dreads the long sleepless nights.

A clinic, with our cardiac patient as the subject, should include, besides the doctors, health teacher, head nurse, and the nurses giving bedside care, a dietitian and occupational therapist. The dietitian can supervise and plan his diet more intelligently if she knows his likes and dislikes and realizes by the condition in which she sees him, and as she hears his case discussed, what he is permitted to eat and would enjoy. Some hospitals have a space on the card for patients' food likes and dislikes. This is kept in the ward kitchen and referred to when meals are being served. It seems an excellent idea.

The occupational therapist has a great contribution to make in the physical and mental health of patients who may need some outlet for a life with new restrictions and

enforced leisure. The patient may find he possesses a variety of unsuspected skills, which in their use give him satisfaction, peace of mind, and even new ways of earning when he returns home.

Through the close integration of all these branches of service, our patient has recovered sufficiently to go home. The private duty nurse has been with him during his stay in hospital and will see him established in his home once more. Through her active interest in public health matters, she has been able to give him and his family much useful information for their daily life, all in the course of her contact during his illness. By now she knows the lay-out of their home and can suggest arrangements to save the patient's energy and the family.

Again we have the close relationship of services on his discharge. Of course, he will see a familiar face when he returns to clinic—his friend, the hospital social worker. And so, with these arrangements completed and his clinic card dated for his check-up visit, our Red Cross workers again call to drive him home. The hospital social worker has already called the district public health nurse to say that he is going home and to tell her of his general condition on discharge.

Arrangements have been made for the Victorian Order nurse to come in and give him a daily bath and to see that all is well at the Smith's. She will, of course, be given the background of her case and the orders and routine to be carried out by the patient. She, too, has kept abreast of hospital procedures and, by her familiarity with all they tell her and ask her, forges another link in our chain of health service.

Still another community service will contribute to Mr. Smith's welfare when he returns to his work. The industrial nurse at his plant has watched Mr. Smith since his previous lighter attack and, of course, has kept in touch with the hospital public health worker during his stay there. On his return to the plant, she will keep a careful check on him to see that he is not overdoing things. Thus she makes her contribution, by her care and vigilance recognizing Mr. Smith's privilege and right to take his place again among his fellow workers.

WHO Recruiting Nurses

Joint WHO/UNICEF programs are developing in the Far East and WHO nursing programs in other regions are being planned. A limited number of well-qualified, experienced nurses will be needed for the following types of work:

1. As members of field demonstration teams to work on special projects with national and local health administrations.

2. To advise and to participate in training programs for nurses, midwives, and auxiliary nursing personnel.

3. To strengthen existing public health nursing services and to assist in improving standards of nursing care and the clinical experience of student nurses in hospital.

In addition, a limited number of positions are anticipated for regional nursing advisers as well as for short-term consultants in public health and other aspects of nursing.

Applications are invited from the following:

A. *Public health nurses* who have had experience in one or more of the following:

1. Polyvalent (generalized) public health nursing services.

2. A specialized field such as maternal and child health, tuberculosis, venereal disease, tropical diseases.

3. Administration and/or teaching in schools of nursing, including public health nursing.

B. *Public health nurses with midwifery* who have had experience in one or more of the following:

1. Polyvalent public health nursing services.

2. Midwifery, hospital, and/or domiciliary.

3. The teaching of midwives.

C. *Nurses with preparation and experience in pediatric and in tuberculosis nursing.*

For further information regarding requirements, duties, salaries, allowances, etc., write to the **Canadian Nurses' Association, 1411 Crescent St., Montreal 25, Que.,** or directly to the **Office of Personnel, World Health Organization, Geneva, Switzerland.**

Public Health Nursing

Family Service in a Generalized Health Agency

MARJORIE WILLIS, B.A.Sc.

Average reading time — 15 min. 12 sec.

A GROUP OF SUPERVISORS from generalized public health agencies met in eastern Canada recently. After discussing the scope of a generalized service, they agreed that although public health nurses readily accept the concept of a family service in theory, they do not always put these theories into practice. This complaint is not a new one. In a study made in the United States in 1937, in which the records of three rural public health nurses were analyzed to ascertain the extent to which the principle of "the family as a unit" was observed in giving health service, the following conclusion was reached:

> Little or no evidence could be found that the nurses were rendering a complete family service . . . Even when all the services rendered to a family during the period of a year were included, less than one-half of the individuals were given attention. Evidently, from the data assembled, the nurses did not render a diversified service when they made a home call . . . !

This conclusion was prefaced by the remark that it was necessarily qualified in terms of the faithfulness of the nurses in recording all services.

I propose to give a brief description of our agency which has a generalized health program. This, with some consideration of the community resources at our disposal, will indicate that we *do* give a family health service.

When I entered my school of nursing to begin training one of the first precepts I learned—which I soon found was to be a major theme throughout the three-year course—was that we must not think of "the appendix" in bed three and "the leg" in bed four. We must think of Mr. Smith who had to have an appendectomy and Mr. Jones who broke his leg last night. Occasionally one would hear a nurse say she was "going to do up the appendix in three" but not very often, and not nurses from our era. We were pretty thoroughly indoctrinated from the beginning with the idea that the *patient* was an *individual*, with his own individual likes and dislikes, pains and worries, responsibilities and joys. His relationship to the ward was of minor importance, since his stay in this environment was usually limited. Naturally we had some contacts with the patient's family and visitors, and we probably became fairly adept at dealing with them; but we were taught to remember that we were *in* our environment and they were *out* of theirs.

In our senior year, when we were beginning to feel fairly sure of ourselves, we were introduced to the community through such media as hospital social service, O.P.D., V.O.N., T.B. control, and the city health service. The contact was brief and we hurried back to the security of our hospital with a maze of interesting and sometimes startling impressions. The understanding we subsequently showed of our patients' relationship to the community varied in quality and in endurance. The important thing is that this brief field experience was a major part of our introduction to preventive medicine—the part

Miss Willis is a staff nurse with the Metropolitan Health Committee in Vancouver.

most responsible for leading us on to specialize in public health nursing.

When we entered university the theme changed. Now, it was *the family*. Very early in our course we studied sociology in terms of this—the basic unit of society—and everything else we learned we adapted to it and its members, and to collections of it, the community.

A question now is posed. Are we, in the rush and pressure of our duties—our everyday routines and special periodic activities plus the startling out-of-the-way events which bring excitement to our work and revision to our work-plans—are we applying our knowledge to the basic unit of society? Are we public health nurses in a generalized program really giving a family service?

Health Units

To evaluate a service, one should first have some idea of the background for it—the agency through which the service is rendered. Our agency is called the Metropolitan Health Committee of Greater Vancouver. It is the official health agency and serves an area of approximately 248 square miles, with a population of nearly 500,000. This area is divided into six units, each administered by a medical director and nursing supervisor and staffed with public health nurses, sanitary inspectors, and clerks. Coordinating the nurses' work is the director of nurses in the central office. Here, also, are the consultants and specialized workers: the educational director, mental hygienists, audiometerists, senior school medical officer, dentists, nutritionists, and quarantine officers. Integrating all these components into a smooth-functioning health department is the medical health officer.

For functional purposes, each unit is divided into districts. In each district there is a public health nurse who serves about 7,000 of the population. Her area corresponds to the school district but do not suppose that her work is similarly limited. Categorically, it has three main divisions—child welfare, school health, and communicable disease control—with the mental hygiene program an integral part of all three.

Child Health Centres

The focal point of the child welfare work lies in the Child Health Centre. These centres are open every one, two, or four weeks, depending on the needs of the area served, and are located so that there is one within reasonable walking distance in each community. One of the routine ways in which new mothers learn about the clinic is through the use of the "Birth Lists." These lists, compiled monthly from data from the Division of Vital Statistics, give the names and addresses of all the babies born in each district. The public health nurse visits, interprets the service, and, if they wish to attend, arranges appointments for them to the nearest child health centre when the babies are six weeks old. She advises the mother concerning any problems that need immediate attention (such things as feeding problems won't wait for clinic day!). She may refer the family to the V.O.N. for a demonstration bath or weighing. On this same visit the nurse will note the mother's appearance and perhaps offer advice about her own health as may be indicated (nutrition, rest, etc.) or she may help her plan her daily schedule to accommodate the new member of the family. Unless it is a "first baby," one of the interesting parts of these visits is consideration of the pre-school children. How do they feel toward the new arrival? Were they prepared for it? Is the mother alert to the need for distributing her attention so that none will lose out on the all-important need for mothering? And, of course, what is their general physical appearance? The answers that the public health nurse gives to these questions determine her future relationship to this family. She may feel that attendance at the child health centre, with appointments later for the preschools' "booster" immunizations, will meet the needs; or she may mark them for periodic home supervision.

Other mothers come to child health centres because of the favorable reports they have heard from mothers already attending. One of the important means of bringing mothers to child health centres is to publicize this service in the other phases of our work. By being alert to such opportunities, the public health nurse can bring this service to the newcomers whose babies were born elsewhere, and to prenatal patients (with referral to the V.O.N. for prenatal supervision and mothercraft classes) whom she often meets in the course of her generalized health program.

Mothers may bring their babies to our child health centres until they are two years old, reporting at the intervals decided on by the public health nurse. Our tangible services include weighing, supervision of feeding and early training, and the immunizations. Our more intangible services include encouragement, "moral support," and the fostering of self-confidence and skill in the mother. Our rewards? The transformation of a harassed and frightened woman, with a wailing infant, to a beaming mother with a healthy rosy child. The competence and self-confidence of the women literally grows before our eyes. There is a gradually decreasing infant mortality rate which may be attributed a little, at least, to these child health centres. They play an important role in the family health service.

The Preschool Child

The child from two to six interests the public health nurse too. After he graduates from the child health centre he is not entirely lost to her until he shows up at school! If a mother appears to need health teaching, in addition to that given at the centre, the public health nurse will continue with home supervision. Also the nurse will observe preschool children in the course of other home visits, concerning school children, or when making communicable disease visits such as tuberculosis or venereal disease. Then, almost before she knows it, she will meet her ex-child health centre babies at one of the district's kindergartens or play schools where she gives health supervision.

This two-to-six period is so vital in the development of attitudes and the establishment of behavior patterns. Here, opportunities present themselves for spotting maternal oversolicitiousness, excessive criticism and restraint, and anxiety. Mental hygiene principles can be introduced in conferences with the mothers, pointing out the meaning of the child's behavior. As the mothers' understanding grows, so will their ability to foster the growth of wholesome, well-rounded personalities in their children. Since study groups, to which the public health nurse may be able to come periodically, afford preschool mothers much instruction and moral support, we are quick to advocate these and help with them as requested. We remember the preschool group in our talks to the Parent-Teacher Association, mothers' groups, or service clubs too, ever alert to give them the important place they merit in the family picture.

The School Child

Now let us welcome these healthy, well-adjusted products of our child welfare program at school! Here we spend about 50 per cent of our time and again we find many opportunities for visiting the homes and getting to know and help our families. Our primary function in school is to promote health by incorporating positive health teaching in all the activities that come within the scope of the nurse. We don't have to be a public health nurse to render simple first aid, or test vision, but we do to recognize the teaching opportunities afforded, and to present our health teaching in a way that will be meaningful to the particular age-group concerned.

Throughout all the procedures that the public health nurse carries out to evaluate the status of the children and foster a still higher health standard, she will be alert to their mental health. Mental hygiene principles will be included in her dealings with

children, teachers, and parents and, where indicated, the special services of a mental hygienist will be enlisted. In these cases the public health nurse prepares the social history and arranges for all interested workers to be present at the conference. Besides giving help to the child and family concerned, such conferences are of educational value to the teachers, social workers, and public health nurses attending.

"Selling" preventive medicine and the importance of early diagnosis and treatment: these rank high in the objectives of a public health nurse in a general service. They are kept well in mind in the school program. The nurse knows that some of her health teaching, if effectively done, will be carried over to the home by the children themselves. The basic principles of preventive medicine, effectively interpreted throughout their school life will lead, we hope, to the practice of having an annual physical examination, which they will assume responsibility for obtaining.

Communicable Disease Control

Here, the public health nurse works closely with other agencies, notably the Divisions of Tuberculosis and Venereal Disease Control and the Quarantine Department. Tuberculosis control is probably the biggest part of this program, the public health nurse doing most of the field work for the Division, which is a provincial department. This includes the supervision of patients "on the cure" at home and the follow-up of contacts. While there are some cut-and-dried precepts for one to follow in this work, each patient is a case unto himself, and to do this work effectively calls for a fair amount of case work. There are real challenges to the public health nurse here—the old tuberculosis patient, who has fixed ideas which may need to be modified, or who is depressed and discouraged, or bored and tempted to over-do; the new one who has little understanding of the disease, who is shocked at his diagnosis and sudden loss of independence for himself and his family, and is faced with the stupendous task of adjusting to a completely new way of living. Yes, indeed! each patient is different, each family presents a new and interesting picture. Without a family service, a tuberculosis service would be relatively valueless, so great a bearing does the essential mental rest have on the cure of the disease.

Referring for Help

Growth in one's ability to give a family service implies increased skill in the use of community resources—social agencies for financial aid or therapeutic case work, the children's clinic for diagnosis and treatment, social service for referral of special problems of patients, etc. Most of these agencies and our collaboration with them are fairly well known. As we grow familiar with our district, their names become associated with names of individual workers, and our knowledge of their different scopes becomes clearer. All the people we want to help won't fall into these categories, though we are surprised to realize that community resources apply to such everyday things as the Sunday school we took for granted when we were younger. We get to know which Cub packs have the shortest waiting lists (meanwhile bemoaning the lack of youth leaders) and we are thankful if we have a Neighborhood House near enough for our families to use. We refer families to the Campers' Association in summer and the Christmas Cheer Committee in winter. We rejoice at having an Occupational Therapy Department in our agency for our patients.

Problems, Too!

One of the pleasant things about our work is the trust and warmth with which we are usually received into the homes. Most parents realize that we have come because we are genuinely interested in their family's welfare and, while some act sooner on our advice, some later, most of them welcome us and talk with us. Some, however, for various reasons, do not want to be "bothered with the nurses"

and their reception is anything but cordial. By repeated, friendly, and, apparently, casual visits, often the most recalcitrant parent can be won over, and some precepts of health imbued in her without her knowing it. Such cases can be hard and discouraging but the least sign of modified behavior buoys us up and makes the effort seem worthwhile. Small gains here equal big gains in a better family.

I have found that it can be harder to teach a mother the importance of a balanced life than the importance of a balanced diet. A family that needs to be taught this so often is a family subsisting on a small income and all its concomitants. In such a home lack of money, lack of knowledge, and lack of ability to budget and plan meals are just some of the more obvious problems. More difficult is the lack of *joie de vivre*—the lack of ability to make some fun in the family. Even more subtle is the mother's feeling of inadequacy due, perhaps, to her own unresolved childhood difficulties, her lack of education, or clothes, or overwork, that makes her shun social intercourse and keep close to her kitchen. Then we get the hopeless irritable parents who create unstable, negative environments, and children steeped in a bath of adult apathy. To be effective, a mental hygiene program must be an integral part of every branch of a family service.

Health and happiness go together. A good public health program is a health and welfare program. A public health nurse, at all worthy of her job in this great work, realizes this.

Human Relations

There are many variables in the performance of a family service. It is generally agreed that human relations are complicated, but human relations in the life of a public health nurse can be about as staggering as any! The staff nurse is the liaison between more different people and organizations than anyone else in the health and welfare set-up. Whereas the contacts of supervisors, doctors, consultants, or specialists with the other people are, of necessity, intermittent and comparatively brief, the nurses' contact is a close, day-to-day affair. School — pupil — parents — nurse; school board — health department — principal — nurse; T.B. patient — patient's family — T.B. medical — T.B. social service — nurse; child health centre — patient — health department — pediatrician — nurse! The number of combinations possible in all these relationships is infinite. She is a newcomer in a school where many of the teachers have been since before she was born. Every home the public health nurse goes into is a new environment. Here it is the patient who is in his environment and the nurse who is out of hers. She must adapt herself and her knowledge of health, her teaching, and interviewing to every home, as to a new job.

The way things have gone in school during the morning will affect the way things go in the district or clinic in the afternoon. If a nurse goes into a home to tell the mother about a child's diseased tonsils and deals only with that, apparently failing to consider that the mother is thin and listless with her housework only half done by mid-afternoon, that the preschool child is barefooted on the cold floor, with pale cheeks and runny nose, and that the dirty dishes in the sink indicate a lunch of greasy pancakes and little else, it is likely because the pressure of other problems in her work at that particular time precludes a more complete service on this visit. A public health nurse cannot help but become more skilled at interpreting such pictures and helping to improve them. To make the best use of her time, she is bound to consider more than the specific health problem which brought her into the home. Just as important, she is bound to consider carefully the laws of learning in her health teaching if she is to teach at all and she is bound to steer a gradual course toward her ultimate goal of fostering independence, the recognition of health and welfare problems by the family, and the assumption of responsibility for them.

We public health nurses are doing these things. Where we may be falling down is in the recording of them. We are accused of using the "not enough time" excuse too much but most nurses will agree that it is a pertinent factor. With so many dynamic and challenging situations in our districts, maybe it is a human enough mistake to place more importance on getting out and trying to do something about them than on leaving a record of our efforts for other nurses to build on.

How to strike a balance, with efficiency and despatch, between service rendered and service recorded—that is a task facing the staff public health nurse in a generalized agency. Only then will her family service be demonstrable and continuity of that service be assured. Then will long-term planning be encouraged with the opportunity for evaluating the effectiveness of her health teaching.

Five Sisters

Something of a record appears to be held by the Lettner family of Nokomis, Sask. Five sisters have completed their training as nurses, four of them being graduates of the Grey Nuns' Hospital in Regina. Can any other Canadian family exceed this record? We would be interested to receive the particulars and, if possible, a photograph.

Four of the sisters are still in active nursing. Reading from left to right we find: **Corinne,** who graduated from the General Hospital, Sault Ste. Marie, in 1935. She went overseas with No. 8 C.G.H., R.C.A.M.C., and served in England, Sicily, and Italy. At present she is in the anesthetic department of the Regina General Hospital. **Blanche** was the first to graduate from the Regina Grey Nuns' Hospital in 1938. She has served as matron in rural hospitals in Saskatchewan and is presently in charge of x-ray and laboratory at the hospital at High River, Alta. **Lillian** graduated in 1942 and is now an embalmer in a Regina funeral home. **Leonore** finished her training in 1944. After engaging in staff nursing in Saskatchewan rural hospitals, she was married. **Phyllis** graduated in 1949 and is at present on the staff of home-town Union Hospital.

Aux Infirmières Canadiennes-Françaises

Mademoiselle Radio 1950

SUZANNE GIROUX

Lecture — 5 min. 36 sec.

CE SERA VOUS—la Mademoiselle Radio 1950—si vous voulez bien suivre mon conseil. Ecoutez la radio tous les lundis soir à 8:30 p.m. et tous les mardis à 8:00 p.m. Je m'adresse à vous qui vous vous proposez de venir au congrès de l'Association des Infirmières du Canada à Vancouver (26-30 juin).

Comment vous préparez à ce congrès? Comment retirer le plus de bénéfice possible des Foyers d'Etudes préparés sur les sujets de la plus grande actualité, en connaissant la technique qui sera employée et ensuite en l'applicant aux sujets à l'étude.

Deux programmes de radio à notre connaissance vous donneront une bonne idée de la technique employée dans les Foyers d'Etude: *Le Choc des Idées*—le lundi à 8:30 p.m. *Les Idées en Marches*—le mardi à 8:00 p.m. Ecoutez-bien! Le sujet traité dans notre cas est secondaire, quoique toujours très intéressant, mais que votre attention se porte sur la technique, la manière de faire. Votre esprit alors sera prêt pour le congrès. Il ne vous restera plus qu'à préparer vos toilettes et faire vos valises.

Où auront lieu ces Foyers d'Etudes? L'Université de la Colombie-Britannique est à notre disposition. L'atmosphère scholastique, le campus, qui est ici un beau tapis de verdure, présentent des conditions favorables à l'étude et à la réflexion.

Qu'entend-on par Foyer d'Etude? Dans un Foyer, dans une famille, chacun donne son idée. Les parents, personnes expérimentées, dirigent la discussion. Les réflexions des enfants ont une influence sur les parents et celles des parents sur la conduite des enfants. Cette influence se fera sentir plus tard à leur travail envers leurs compagnes, etc.

Vous comprenez maintenant pourquoi l'on a donné ce nom de Foyer d'Etude aux conférences qui auront lieu au congrès.

Chacune aura le privilège de donner son idée sur le sujet traité. Toutes les idées exprimées, les réflexions faites, les suggestions apportées seront réunies; nous reviendrons plus riches, ayant bénéficié de l'expérience des réflexions des unes et des autres.

Quelle est la technique employée? Voici comment l'on procède. Une personne est chargée de diriger le Foyer d'Etude. Son rôle est de se taire le plus souvent possible mais elle doit voir à ce que tout marche bien. Une question, un problème est exposé, question importante qui retiendra l'attention des membres du Foyer mais qui tout de même est à la portée de tous. Des spécialistes en la matière sont invités; ils sont chargés d'exposer les faits.

Les membres de la conférence se divisent par groupe de 12 à 18 (véritable Foyer Canadien-français!). Chaque Foyer a une *convocatrice*, une personne capable d'animer une discussion; une *observatrice* dont le rôle est de juger de la valeur de la discussion; une *secrétaire* qui fera rapport des activités de son petit groupe.

Comment assurer le succès d'un Foyer d'Etude? La réponse est simple: en s'y préparant.

(1) Le programme est préparé avec

Mlle Giroux est en charge des Foyers d'Etudes pour les infirmières françaises au congrès de l'A.I.C. en juin.

soin par les personnes devant y prendre part. (2) Les membres, assistant au Foyer d'Etudes, doivent venir préparés à y prendre une part active. (3) Des assistantes doivent être préparées afin d'assurer plus grand rendement possible. (4) Quelques-unes de ces assistantes doivent être préparées avant le congrès. (5) Il faut s'arrêter et examiner le travail accompli. (6) La discussion se fait par petit groupe. Les rapports de chacun des groupes sont communiqués à l'assemblée générale (réunion de tous les petits groupes étudiant le même sujet). (7) Le communiqué de ces rapports a pour but de faire connaître les divers points de vue. (8) Cela permet également, en comparant les rapports de chaque groupe, de juger de la valeur de la discussion de notre petit groupe. (9) L'observatrice, qui elle aussi fait son rapport, nous présente, en quelque sorte, un miroir, un tableau de notre discussion, libre à nous de retrancher, d'ajouter. (10) Le groupe s'engage à répandre, à propager les décisions prises lors de la conférence.

FOYER D'ETUDE EN FRANÇAIS

Pour la première fois l'A.I.C., lors d'un congrès biennal, organise des séances en français. Nous invitons toutes les infirmières de langue française à y prendre part, particulièrement nos campagnes des provinces maritimes, de l'Ontario, du Manitoba, et toutes les autres qui voudront se joindre à nous, et naturellement celles du Québec.

Le sujet discuté—Le travail d'équipe en nursing: Jadis, il n'y avait que le médecin et l'infirmière auprès du malade. Auprès du bien portant, il n'y avait personne pour le conseiller sur les moyens à prendre pour conserver sa bonne santé. Aujourd'hui, le médecin et l'infirmière sont toujours au chevet du malade mais en plus l'on rencontre la diététiste, l'auxiliaire sociale, l'aide, etc., travaillant tous ensemble au rétablissement du malade.

En hygiène publique l'on rencontre le médecin et l'infirmière, mais non dans un rôle de soignante mais d'éducatrice. Elle aussi fait appel à la diététiste, à la travailleuse sociale, à l'aide entraînée pour donner des soins à domicile, etc.

Notre société a-t-elle besoin de toutes ces personnes? Quel est le rôle de chacune? Vous avez une opinion sur la question, une idée, une suggestion? Venez les exposer au congrès de Vancouver du 26 au 30 juin.

Victorian Order of Nurses

The following are recent staff changes in the Victorian Order of Nurses for Canada:

Appointments: Montreal: *Mrs. Eugenie Wilson* (Vancouver Gen. Hosp.). Sackville: *Frances Cook* (Ottawa Civic Hosp.). Saskatoon: *Margaret Cawsey* (Royal Alexandra Hosp.). Winnipeg: *Olive Blair* (Winnipeg Gen. Hosp.).

Re-appointments: *Mrs. Evelyn (Berens) Cash* to Montreal; *Mrs. Nita (Enns) Seibert* as nurse-in-charge at Peninsula, Ont.; *Winnifred Tredaway* as nurse-in-charge at North Bay; *Marion McEachran* to Regina.

Transfers: *Phyllis Farmer* from Regina to Prince Albert as nurse-in-charge; *Blanche MacPherson* from Halifax to Yarmouth as nurse-in-charge; *Inez Rickinson* from Peninsula to Lincoln County.

Resignations: *Gwendolyn Angus* from Sackville, *Mildred Irwin* from Calgary, *Constance MacDonald* from Cornwall, *Muriel E. Philip* from Montreal to take up other work; *Isabel Goward* from Prince Albert and *Mrs. Edna (Valiquette) Mulligan*, North Bay, to be married; *Muriel Rice*, North Bay, and *Mrs. Helen Tallman*, Montreal, to attend to home responsibilities; *Mary McLennan* from Vancouver to retire.

The young man who has not shed tears is a savage, and the old man who will not laugh is a fool.

—GEORGE SANTAYANA

Nursing Profiles

When **Ida Evelyn Johnson** entered the school of nursing of the Royal Alexandra Hospital, Edmonton, in 1922 to begin her professional training, she did not dream that in November, 1949, she would step into the role of superintendent of nurses. Born in Cranbrook, B.C., Miss Johnson received her secondary school education in Alberta. A firm believer in the value of post-graduate study, she holds her certificate in operating-room technique from the Woman's Hospital, New York, and in school of nursing administration from the University of Western Ontario, London.

After only four months in private duty following graduation, Miss Johnson became assistant to the operating-room supervisor at R.A.H. She later became the supervisor herself, serving many years in that capacity. For the past five years she has capably filled the position of assistant superintendent of nurses there.

Miss Johnson has always been interested in the work of nursing organizations. She has held numerous offices, including the presidency of both her own alumnae association and of the Alberta Association of Registered Nurses. She is also a firm believer in nurses taking part in community activities. She belongs to the Navy League of Alberta as well as business women's clubs. She is interested in music and plays the piano for her own enjoyment. Gardening and golf provide out-of-doors activity. She receives the greatest pleasure and stimulation from the many people she has met through all her various contacts, including attendance at the 1949 Conference of the International Council of Nurses.

Miss Johnson has a strong faith in the young women who are entering our schools of nursing that they will accept professional responsibility even as she has through the years.

Little Studio, London

IDA JOHNSON

Myra E. Young, who has been matron of the Fernie (B.C.) General Hospital since 1925, has retired. Graduating in 1912 from the S. R. Smith Infirmary, Staten Island, New York, Miss Young took post-graduate courses in eye, ear, nose and throat work and also in obstetrics. In 1918 she moved to western Canada for reasons of health and engaged in private duty. Later she took an extended course in radiology and x-ray work at the Royal Alexandra Hospital, Edmonton.

This very broad background stood Miss Young in good stead in her early days at Fernie. She was able to fill any role in hospital service and has earned the loyal esteem and gratitude of all the citizens of Fernie because of the skill with which she has coped with difficulties as they have arisen through the years.

Miss Young has been succeeded by **Margaret Saunders,** formerly of Calgary.

MYRA E. YOUNG

Designed to provide medical care at strategic points throughout the vast northland to prevent the spread of disease and to provide emergency nursing service, the Department of National Health and Welfare has appointed **Mrs. Margaret Emond,** a graduate of the Cornwall General Hospital, Ont., to a health outpost at Fort Chimo on Ungava Bay and **Mildred E. Steele,** of Beechy, Sask., to Lake Harbor on Baffin Island.

Gertrude Reid, who has faithfully served in New Toronto as a school nurse since 1923, has retired. At a tea in her honor, representatives of the Board of Health, Board of Education, and town council expressed their appreciation of Miss Reid's splendid work. She was presented with a set of travelling bags in recognition of her services. **Mrs. J. P. LaFlair** has been appointed to succeed Miss Reid.

In Memoriam

George M. Weir, who is best known to Canadian nurses as the author of the "Survey of Nursing Education in Canada," commonly referred to as the "Weir report," died in Vencouver on December 4, 1949, at the age of 64. Dr. Weir had been in failing health since June, 1946.

During his years as provincial secretary in the B.C. legislature, Dr. Weir fought hard to put into effect a program of health insurance which was to have provided benefits for workers earning $1,800 or less. Although the measure was never enacted because of strong opposition, it became the forerunner of the present B.C. Hospital Insurance Act.

* * *

Ethel M. (Roblin) Beckhorn, who received her nurse's training in Toronto and who went overseas with the Queen's University Hospital Unit in World War I, serving in England and Salonika, died on November 30, 1949, at the age of 59. Mrs. Beckhorn had retired from active work two years ago because of ill health.

* * *

Mary E. (McLeod) Gordon, R.R.C., who served as a nursing sister during World War I in England, France, the Dardenelles, and Egypt, died in Brandon, Man., on November 9, 1949, at the age of 66.

* * *

Susan Haddock, who graduated from the Brandon General Hospital, Man., in 1912, and who spent 25 years as a missionary nurse in West China, died in Vancouver on October 12, 1949, at the age of 70.

* * *

Jessie McKinnon, who received her nurse's training in Edinburgh and who, years ago, engaged very actively in nursing in and around Portage la Prairie, died on November 19, 1949, at the age of 78.

* * *

Claribel McMillan, an intermediate student nurse at the Stratford General Hospital, Ont., succumbed to injuries received in a car accident on November 4, 1949, at the age of 22.

* * *

Rose Marie Rouse, who graduated from St. Joseph's Hospital, Toronto, in 1925, died on November 30, 1949, at the age of 45. She had been in ill health for the past year. For more than 20 years Miss Rouse had been on the staff of the St. Elizabeth Visiting Nurses Association in Toronto.

* * *

Alice Ellen Stewart, who was superintendent of nurses at the Sherbrooke, (Que.) Hospital from 1898 to 1905, died in Hamilton, Ont., on November 30, 1949.

* * *

Jean Usher, who graduated last year from the University Hospital, Edmonton, died on November 8, 1949, following a brief illness, at the age of 22.

Trends in Nursing

Average reading time — 11 min. 12 sec.

News from the Provinces

British Columbia reports that the Committee on Arrangements, C.N.A., has organized a committee widely representative of Vancouver nurses. They are all looking forward to having the privilege of playing hostess to nurses from all parts of Canada. In December, the Registered Nurses' Association of British Columbia was granted representation on the Survey Committee. Following submission of a brief from the association and a formal request from the University of British Columbia, a grant was received which enabled the Department of Nursing and Health to purchase equipment for a nursing arts laboratory. The provincial government conducted a survey of which Lucile Petry, chief, Division of Nursing, United States Public Health Service, undertook the nursing portion. Miss Petry worked in close cooperation with the association and included in her study the nursing needs of the province so that there is every reason to believe that her recommendations will not be limited to nursing service needs in hospitals.

Amendments to the constitution, approved at the annual meeting, added one new object, namely, "To promote and regulate sound employee-employer relations in the nursing profession." Personnel practices were revised to make the following changes:

1. Basic minimum salary for registered nurses, $175 per month, subject to adjustments conforming to fluctuations in cost of living index.
2. Differential of $10.00 between salary for a registered nurse and that for a non-registered nurse.
3. Basis for charges made for residence and meals to be actual cost.
4. A formula for computing the daily wage for temporary employment.

The association is now a party to 13 agreements signed on behalf of the nursing staff of 12 hospitals and one public health service. The association used the National League of Nursing Education State Board tests in the September, 1949, examinations with better than good results. The Student Nurses' Association is active.

Manitoba: Effective January 1, 1950, the Association of Registered Nurses will recognize three types of membership: (1) Active practising membership; (2) active non-practising membership; (3) inactive membership. An Instructors' Workshop was held on June 20, 1949. Approval was given to the $2.00 per capita affiliation fee to the C.N.A. and to the donation of $50 to the C.N.A. fund for travel expenses of European nurses to the I.C.N. Conference in Sweden.

It was decided that a Study Committee be appointed by the Board of Managers to consider implications of governmental subsidies for nursing education. The following recommendations were forwarded to the general secretary, C.N.A.:

1. THAT governmental subsidies for nursing education should be allocated at the provincial level of government; that such subsidies be not given to individual student nurses but rather to schools of nursing primarily for improving methods of nursing education, and that the merits of the school of nursing as distinct from its size should determine its eligibility for governmental subsidy.
2. THAT a national survey of nursing service needs should precede any extensive plan for subsidizing nursing education.
3. THAT a commission should be established to act as a policy-forming body and in an advisory capacity to the governmental official or department responsible for the administering of governmental subsidies to schools of nursing if and when such are made; that two-thirds of the members of such com-

mission shall be professional nurses nominated by the provincial registered nurses' association.

New Brunswick: The members of the Institutional Nursing Committee completed the minimum curriculum and it was ready for the fall term. The amendments to the Registered Nurses' Act became effective January 1, 1950. Plans are being made for a nursing school adviser on an interprovincial basis with the Prince Edward Island. Membership fees were raised to $10.00 and will include *The Canadian Nurse* and the increased affiliation fee of $1.00 to the C.N.A.

Nova Scotia: The association has been informed by the Minister of Health that the Ministry proposes to set up a Health Survey Committee for the purpose of determining existing health, hospital, and other related facilities prior to any decision as to allocations from the Federal Health Grant. An Advisory Committee has been set up to facilitate the work of such a Health Survey Committee of which the president of the Registered Nurses' Association is a member. Dalhousie University, Halifax, is giving a post-graduate course in public health nursing and a course for undergraduates. An Educational Policy Committee has been set up under the convenership of Rhoda MacDonald.

Ontario: The new office at 515 Jarvis St., Toronto, will provide a centre for committee meetings. Nettie D. Fidler has resigned as president and Rahno M. Beamish has accepted the office. The Legislation Committee is working on a needed revision of association by-laws. The Continental Casualty Co. group disability plan, sponsored by the association, now covers membership of all districts. The industrial nurses formed a temporary organization of their own in June and are asking that a committee or section, within the association, be formed. There was a lack of interest on the part of students in a student nurses' association.

Prince Edward Island: A new Nurse Practice Act comes into effect January 1, 1950. Four bursaries to graduate nurses for post-graduate study were given by the provincial Health Planning Commission. Financial assistance from the Health Planning Commission is helping to set up a provincial office and registry. Plans are underway to secure the services of a school of nursing adviser jointly with New Brunswick.

Quebec: A provincial survey is being conducted under the direction of Dr. J. E. Sylvestre. Suzanne Giroux is active on the sub-committee on Professional Training. Twenty-one displaced European nurses are enrolled as nursing aides in hospitals. These nurses require a centralized plan of instruction, designed to meet their needs, to supply deficiencies and to prepare the group for licensing and the practice of nursing. Through the co-operation of McGill School for Graduate Nurses and of the Children's Memorial Hospital, a course of instruction in pediatric nursing is being arranged.

Saskatchewan: Lola Wilson has been appointed assistant registrar. Six bursaries were awarded to nurses for post-graduate work. The special studies of the health program have continued. The Health Services Planning Commission accepted responsibility for the technical work of the study made during the summer. Revision of recommendations, relating to nursing personnel, is planned. An affiliation in psychiatry at the Munroe Wing, Regina General Hospital, has been organized on an experimental basis by funds from the Federal Grant. Re-organization of examinations for nurse registration is under consideration. A grant of $1,500, to assist with the work of Nurse Placement Service, has been received from the provincial government. A willingness to increase the annual fee to the C.N.A. in 1950 to $2.00, if this policy is generally endorsed by other provinces, was reported.

Educational Policy Committee

Evaluation of schools of nursing: No steps have been taken to enlarge the provisional committee to study eval-

uation in view of the fact that at the last Executive meeting the resolution, recommending that a national program of evaluation should be instituted by the C.N.A., was tabled. However, in view of the fact that evaluation is one of the Work Conference topics at the forthcoming biennial, a small Montreal provisional committee has continued to meet. Margaret Street, the convener, reported upon an institute which she had attended in New York recently, in which the technique of evaluation was dealt with very effectively.

The members were interested in her report and in what has been done in the U.S.A. (See the October, 1949, *A.J.N.* for the editorial on "Accreditation and Classification" and the first release by the National Nursing Accrediting Service, 1949, of approved programs in nursing.) It was felt that we must avoid any tendency to establish too uniform a level in our schools, that only basic requirements should be considered in evaluation, and that scope must be allowed for variation and research.

It was decided that the present provisional committee should keep in touch with evaluation programs so that we will be prepared to supply leadership when funds are available for evaluation in Canada. The following motions were carried:

THAT the Provisional Committee on Evaluation of Schools of Nursing make a study of the cost of evaluation for our information.

THAT the Committee on Educational Policy affirm its belief in the principle of nationally organized professional nursing groups assuming responsibility for accreditation on a national basis of educational programs in nursing.

THAT the Executive Committee, C.N.A., be requested to take active measures to implement a national program of evaluation of schools of nursing as a first step toward the establishment of a national program for the accreditation of all educational programs of nursing.

The ratification of these motions was given by the Executive Committee.

Government support for nursing education: At the C.N.A. Executive meeting, held in Winnipeg in March, 1948, the following resolution was passed:

THAT the Committee on Educational Policy be asked to study the question of government support of education in various fields, and the conditions under which the professions concerned feel that it is satisfactory, and to bring in a suggested educational policy for the C.N.A.

Nothing could be done before the C.N.A. met in Sackville but, in discussing the possibilities of such a study at the first Executive meeting afterwards, it was agreed that, before the chairman could proceed to undertake this commission, we needed technical, particularly statistical, help; that we needed a full-time person as an educational secretary to make personal contacts and get information as well as to develop some kind of interviewing technique. It was also necessary for us to know whether, if some worthwhile program involving support by government funds was proposed, it would have professional backing in all the provinces.

At the request of the Educational Policy Committee the general secretary asked the provincial associations' approval or otherwise of a plan being brought forward for consideration, which would involve seeking governmental support for nursing education.

When the provincial replies were available, the general consensus was that they favored the principle of government-supported nursing education, providing the nursing profession is able to retain the necessary supervisory control.

There was discussion on the relative values of making our own approach to government or joining other groups, as was done through the C.N.A. Joint Committee (C.M.A., C.H.C., and C.N.A.) when an approach was made to the Minister of Health and Welfare for financial support to conduct a national survey of nursing. It was agreed that before

any further approach to government is made we nurses need to know what it is we want to propose. There is some urgency, if the Metropolitan School of Nursing is to continue as an independent school, that every channel of possible income be pursued.

The following motion was approved:

THAT Agnes Macleod be appointed chairman of a Core Committee, selected by herself, to initiate action immediately on the previous recommendation regarding the approach to governments for financial aid for nursing education.

Delineation of functions: The provincial associations did not agree with the resolution concerning the inclusion of intravenous therapy in the basic nursing course, although replies were not received from all of them. There can be no further action at this time, although it behooves all of the nursing service administrators to know whether this procedure is being carried out by nurses in their areas of control or not, and that, if there is necessity for such practice, the graduate nurses are given sufficient instruction to ensure safety in their technique.

Sub-committee on Auxiliary Workers: The following amended resolution was passed:

WHEREAS, It is becoming increasingly apparent that there is an urgent need for clarifying the scope of and the relationship between the professional and the auxiliary nursing fields; and

WHEREAS, Such clarification is in the interests both of the public and of the professional and the auxiliary nursing groups; therefore be it

Resolved, That the Committee on Educational Policy recommend that the Executive Committee, C.N.A., refer to the provincial Committees on Educational Policy the need for a study of the functions of the professional nurse and those of the auxiliary nursing worker, with the purpose of making a more precise delineation of professional nursing and of auxiliary nursing.

Metropolitan School of Nursing

Registration of graduates: The first and second groups have all successfully passed the Ontario Registration Examination, Part I. The first group wrote the final registration examination in November, 1949.

Reciprocal registration: At a meeting of the Demonstration School Administration Committee it was decided to write to the provincial associations, asking them if they could state whether the graduates of the Metropolitan School, who are eligible for registration in Ontario, would have the same privileges of reciprocity that the graduates of other approved Ontario schools enjoy. From replies received, it would appear that this matter is satisfactorily cleared in seven provinces. The Registered Nurses' Association of Nova Scotia writes that if, as is hoped, their Bill is passed in the spring of 1950, it will contain a provision for granting reciprocal registration to graduates of the school. A final reply has not yet been received from Alberta.

Students: Class of Spring, 1950—One married student withdrew on the advice of her physician. The group now numbers 11. Class of Autum, 1950—Of the original group of 24, one student withdrew to be married. Class of 1951—24 students were admitted on Sept. 12, 1949. For this class there were: Enquiries, 317; applications, 75; refused and withdrawn, 51. Class to be admitted in Sept. 1950—Enquiries, 27; applications, 8.

Christian Fellowship

Plans for a graduate nurses' Christian Fellowship in Vancouver have materialized. The group convenes the second Monday of each month at the home of the president, *Miss Mary Bell, 2718 Alberta St., Vancouver, B.C.*

All visiting graduates are welcome. We would be pleased to correspond with members of any similar group.

Orientation et Tendances en Nursing

Nouvelles des Provinces

Colombie-Britannique: En vue du congrès biennal, l'Association des Infirmières du Canada a organisé un comité du programme dont les membres sont en grande partie de Vancouver. Elles anticipent le privilège de recevoir les infirmières du Canada. En décembre, l'on accorda à l'Association des Infirmières Enregistrées de la Colombie-Britannique d'être représentée sur le comité de l'enquête des services de santé.

Le Département du Nursing et de la Santé de l'Université de la Colombie-Britannique organise un laboratoire sur l'art du nursing, un octroi leur a été accordé à cet effet, à la suite d'un exposé présenté par l'association des infirmières de cette province et d'une demande dans le même sens faite par l'université.

Le gouvernement de la province a fait une enquête sur les services de santé. La partie concernant les infirmières fut confiée à Lucile Petry, de la section du nursing du Département de la Santé Publique des Etats-Unis. Mlle Petry a travaillé en co-opération étroite avec l'A.I.C.B. Elle a inclus dans ce travail sur le nursing les besoins de la population, ce qui porte à croire que ses recommandations ne se limiteront pas aux besoins des hôpitaux.

Les constitutions de l'association ont été amendées et le but suivant, comme fin à atteindre, a été ajouté: "Promouvoir et réglementer une bonne entente entre employeur et employées dans la profession d'infirmière." Le salaire minimum de $175 a été recommandé pour les infirmières enregistrées. Les repas et le logement seront chargés au prix courant. L'association est agent mandataire et a signé des conventions collectives pour 12 groupes d'infirmières dans les hôpitaux et un groupe en hygiène publique.

A titre d'expérience, les élèves infirmières de cette province ont passé les examens de la "National League of Nursing Education"; elles ont remportées un succès éclatant.

Manitoba: L'Association des Infirmières Enregistrées du Manitoba a approuvé qu'une cotisation de $2.00 par membre, soit versée à l'Association des Infirmières du Canada.

Un comité fut nommé dans le but d'étudier l'octroi de subsides pour l'éducation des Infirmières. Il fut recommandé que:

(1) Toute aide, accordée par le gouvernement, soit versée à l'école plutôt qu'aux élèves individuellement; que ces octrois versés aux écoles le soit dans le but d'améliorer les méthodes dans l'éducation de l'infirmière; que ces octrois soient versés d'après la valeur de l'école et non d'après la dimension de l'école.

(2) Qu'une enquête nationale sur les besoins de la population, en regard des infirmières, soit tenue avant qu'il soit question de verser des octrois aux écoles d'infirmières.

(3) Que, si la recommandation de verser des octrois aux écoles d'infirmières est acceptée par le gouvernement, un comité consultatif soit formé dont les 2/3 seraient des infirmières nommées par l'association des infirmières de la province.

Nouveau-Brunswick: Le programme scolaire pour les élèves infirmières vient d'être terminé et était en usage lors de l'ouverture des cours en septembre dernier.

L'association provinciale a approuvé d'augmenter d'un dollar par membre la cotisation à l'A.I.C. La cotisation payable par chaque infirmière de l'Association des Infirmières Enregistrées du N.B. est de $10.00 et chaque membre reçoit la revue, *The Canadian Nurse.*

Nouvelle-Ecosse: Le Ministère de la Santé a informé l'Association des Infirmières Enregistrées de la Nouvelle-Ecosse qu'un comité sera formé dans le but de faire un relevé de toutes les organisations de santé, hôpitaux, associations, etc., en existence avant qu'il soit question d'octrois fédéraux de santé. L'Université de Dalhousie, Halifax, donne un cours post-scolaire en hygiène publique et un autre cours sur la même matière aux élèves infirmières.

Ontario: La nouvelle présidente de l'Association des Infirmières Enregistrées de l'Ontario est Rahno M. Beamish. Elle remplace Nettie D. Fidler.

Tous les districts de la province ont des infirmières faisant partie de l'assurance groupe de Continental Casualty Co. Les infirmières employées en industrie se sont organisées en un groupe particulier et elles ont demandé à l'association de former un comité ou une section permanente de leur groupe.

Ile du Prince-Edouard: Une nouvelle loi, régissant la profession d'infirmière, est entrée en vigueur en janvier. Quatre infir-

mières ont reçu des bourses d'étude, provenant des octrois des services de santé. Des subsides, provenant de la même source, permettront d'organiser un bureau et un registre provincial.

Québec: Un relevé provincial est actuellement dirigé par le Dr. J. E. Sylvestre du Ministère de la Santé. Un des membres, Suzanne Giroux, travaille activement au sous-comité de la formation professionnelle.

Vingt et une infirmières, déportées d'Europe, ont été placées comme aides dans nos hôpitaux. Un programme d'étude, spécialement organisé pour elles, leur est donné en vue de les préparer aux examens.

Saskatchewan: Une affiliation en psychiatrie a été organisée à titre d'expérience, grâce à l'aide obtenue provenant des octrois des services de santé. Le bureau de placement pour les infirmières a reçu $1,500 du gouvernement provincial.

L'Association des Infirmières Enregistrées de la Saskatchewan est prête à augmenter à $2.00 la cotisation payable à l'A.I.C. si le même geste est fait par les autres provinces.

Le Comité de l'Education

(Chargé de déterminer la politique adoptée par l'Association des Infirmières du Canada en matière d'éducation)

Evaluation des écoles d'infirmières: Rien n'a été fait pour augmenter le nombre des membres de ce comité chargé d'étudier la recommandation d'instituer un programme national d'évaluation des écoles d'infirmières, étant donné que ce projet a été ajourné lors de la réunion du conseil de l'A.I.C. Néanmoins, l'évaluation des écoles sera le sujet d'une conférence d'étude lors du congrès biennal. A Montréal un petit comité continue à étudier cette question. La convocatrice, Margaret Street, a assisté à des journées d'études à New York où la technique de l'évaluation et sa valeur ont été démontrées.

Le gouvernement doit-il prendre à sa charge les écoles d'infirmières? Lors de la réunion du Comité de Régie de l'A.I.C., tenue à Winnipeg en mars, 1948, la résolution suivante fut approuvée:

"Que le Comité de l'Education soit chargé d'étudier l'aide que le gouvernement apporte à l'éducation dans différents domaines et à quelles conditions cette aide pourrait contribuer d'un manière satisfaisante à mettre en pratique la politique recommandée pour la profession d'infirmière."

Avant de faire des démarches auprès du ou des gouvernements, la convocatrice du Comité de l'Education aurait besoin de certaines statistiques; en plus elle estime qu'une secrétaire employée à temps complet serait nécessaire.

Sous-Comité des Aides: Il semble urgent de mettre au point quel est le domaine de l'aide en rapport du domaine réservé à l'infirmière. Il a été proposé que tous les comités provinciaux de l'éducation étudient les fonctions réservées à l'infirmière et celles qui peuvent être confiées aux aides, afin qu'une ligne de démarcation soit tracée entre les deux.

L'Ecole d'Infirmières Metropolitan

L'enregistrement des diplomées: Deux groupes d'élèves ont passé avec succès les examens d'enregistrement de l'Ontario. Le premier groupe a passé les examens finals en novembre 1949, et le deuxième a passé l'examen d'enregistrement de la première année.

L'enregistrement par réciprocité: Le Comité d'Administration de l'Ecole de Démonstration Metropolitan a décidé d'écrire aux associations provinciales, afin de savoir si les diplômées de l'école, ayant obtenu leur enregistrement dans l'Ontario, pourront obtenir l'enregistrement dans les autres provinces. D'après les réponses reçues de sept provinces, il semble décidé que les provinces accorderont le privilège de l'enregistrement à ces élèves. L'Association des Infirmières Enregistrées de la Nouvelle-Ecosse espère pouvoir répondre dans le même sens lorsque la nouvelle loi des infirmières sera adoptée. Une dernière réponse est attendue de l'Alberta.

Elèves: La classe, devant graduer au printemps 1950, compte 11 élèves; une élève mariée s'est retirée sur le conseil de son médecin. La classe de l'automne 1950, compte 23 élèves; une est partie pour se marier. La classe de 1951 compte 24 élèves. Pour cette dernière entrée 317 demandes d'information furent reçues, 75 demandes furent faites, et 51 candidates furent refusées ou se retirèrent d'elles-mêmes.

Age selection pattern of poliomyelitis in Canada, with the exception of the 0-4 age group, has shown little change. While it may attack any person in any age group from 0 to over 50, the most susceptible age group at present is 5-9.

June in Vancouver

Isn't it lovely at this time of year to think of June in Vancouver and of meeting and conferring with friends on the beautiful University of British Columbia campus overlooking the Sound? We hope, if the weather is kind, that many of the discussion groups will meet out of doors and that, while we are refreshing our minds, our bodies may luxuriate in the sights and scents of summer days.

The following outline will give you a preview of what the consulting team on Evaluation and Accreditation of Schools of Nursing is preparing for us. Dorothy G. Riddell, inspector of Training Schools for Nurses, Ontario Department of Health, has been added to the team of consultants noted in the January issue.

General Plan for Conferences

General aim—To acquaint the faculty members of schools of nursing and all concerned with educational programs in nursing with current trends in evaluation and accreditation programs in order to develop interest that may stimulate a desire for more knowledge on this subject and lead to some definite action.

Conference purposes—(1) To discuss the meaning of the terms "evaluation" and "accreditation." (2) To consider methods employed in evaluating and accrediting educational programs in schools of nursing. (3) To consider why an evaluation and accreditation program is indicated, what it proposes to do, and the profession's responsibility for inaugurating such a program. (4) To consider how evaluation and accreditation can improve nursing education, nursing service, and health standards in your community. (5) To consider plans for implementing an evaluation and accreditation program in Canada.

Methods—These conferences are to be conducted as active discussion groups. Individual groups may concentrate on the area of particular interest to them. There will be a chairman, a secretary, and an observer for each group. Group reports will be mimeographed and available for all members.

Plan—Work conference will extend from June 27 to 29 from 2:00 to 5:00 p.m.

Registration for each conference will be limited in the interest of good discussion. Those wishing to attend this conference should make application at the earliest possible date. Application forms will be available through your provincial office.

The same general pattern will be followed for each work conference, as follows:

First Day—*Total group:* (a) Brief introduction to work conference method. (b) Introduction to conferences (panel). *Small groups:* Development of group objectives. Anticipated results of an evaluation program from point of view of: (a) Hospital administration. (b) Nursing education. (c) Nursing service. (d) Profession of nursing.

Second Day—*Total group:* The accreditation process. *Small groups:* Preparation for the school visit: (a) Participation of hospital board. (b) Co-operation of faculty members in preliminary work. (c) Function of visitor in relation to school. (d) Interpretation of visitor's report.

Third Day—*Small groups:* Methods of interpreting need for program. *Total*

group: Implementation of program in Canada.

TRANSPORTATION

The October number of the *Journal* carried information secured through the courtesy of Trans-Canada Air Lines on air travel plans to Vancouver. Rates were quoted for groups of ten or more travelling together. A recent letter has further interpreted this group scheme:

> Group rates apply when a party of ten or more travel from a common point of origination to one destination. On the outward trip members of the group must travel within 24 hours of the first one of the party. For the return trip the group members can return individually, leaving when they so desire up to four months from the date the ticket was purchased. For example—Five people leave Montreal on June 10 and five on June 11 for Vancouver, returning from Vancouver on separate dates with all the privileges of a regular ticket, regarding time of departure stop-overs, and routings.

In The Good Old Days

(The Canadian Nurse, February 1910)

"Montreal is just recovering from a typhoid epidemic—an epidemic which was alarming because it seemed loath to abate . . . There were some three thousand cases in the city with many new cases being reported daily . . . An emergency hospital (with) the Victorian Order nurses to attend to the nursing was launched . . . in a large factory on Aqueduct Street . . . Saturday, the dust-laden factory; Tuesday, a clean, well-equipped hospital, with every appliance at hand to bring back the sick to health and vigor."

* * *

"Teachers College is about to inaugurate, through its new School of Household Arts, a public service movement of large promise. In brief, the college plans to train a body of teacher-nurses to carry the theory and practice of physical welfare for children and of hygienic living in general into homes, schools, and communities. Through the munificence of Mrs. Helen Hartley Jenkins, an endowment has been provided for instruction in the science and art of hygienic living, with the special object of training women for public services as visiting nurses in home and school, teachers in farmers' institutes, and sanitary experts in the training of children in city and country."

* * *

"The Welfare Committee (in Toronto) hopes ere long to open pure milk depots where mothers can secure the best milk obtainable at a nominal cost, and hope the day is not far distant when 3-cent lunches will be served in our public schools, as is done in New York, as the child of the working mother has little chance of much nourishment at noon hour and soon may the need of school baths be recognized by those in authority."

* * *

"The Ladies' Auxiliary for Kincardine Hospital are desirous of acquainting any parties who would like to contribute feathers for hospital pillows that they will be pleased to furnish the ticks for them."

* * *

"The nurses' home at the G. & M., St. Catharines, is to be enlarged and improved. The new operating equipment is first class, so is the steam table in the diet kitchen. Our staff doctors are giving the nurses splendid lectures again this year."

The WHO special committee that has been studying the action of various insecticides has found that "in certain countries the control of anophelines by spraying with residual-action insecticides has, in the absence of any sanitary methods, contributed to the disappearance of flies, whose importance in the propagation of disease is becoming more and more widely recognized.

"However, to make the best use of new insecticides, it is essential in fly control to ascertain certain useful biological data, such as their habits and habitat. As it has been recorded that strains of houseflies, which are resistant to DDT, have evolved after DDT-treatment of dwelling places, it is preferable to use other insecticides, such as chlordane or BHC. Research should be carried out on the possibility of prolonging the residual action of these insecticides."

Student Nurses

Methemoglobinemia

ISABEL E. MACLACHLAN

Average reading time — 7 min. 48 sec.

SANDY, AGED SIX WEEKS, was the fourth child of healthy, normal parents who lived on a farm. The other three children were all healthy. Sandy had weighed six pounds at birth and had developed well as a bottle-fed baby. Occasionally he vomited slightly following his feedings. No significance was attached to this at the time.

On the day of admission to hospital, Sandy had had his first bottle of the day at 4:30 a.m. When his mother put him back into his bed, he appeared normal in every way. Yet when she went to him at 6:15 a.m., she found Sandy was breathing with great difficulty and was cyanosed. It was a distance to hospital but as soon as he had been admitted at 11:40 a.m., oxygen with carbogen 7% was administered every 20 minutes for 5 minutes, by mask. When Sandy was taken to the x-ray for chest examination, the oxygen therapy was continued uninterruptedly.

Penicillin was ordered by the doctor —20,000 units immediately followed by 10,000 units every 3 hours. An intravenous of glucose was started as Sandy was given nothing by mouth. The x-ray findings were essentially normal with "no opacities apparent within the lung fields to indicate gross lesion." The laboratory report on the blood tests showed a white blood cell count of 20,600 with toxic granulation present. The urine was slightly cloudy with approximately 10% methemoglobin present in the specimen.

Despite the continued oxygen therapy, no improvement in Sandy's color was noted. This, coupled with the laboratory findings, led to the conclusion that he had methemoglobinemia. Therefore, 0.5 cc. of methylene blue, 1%, was given via the intravenous.

Experimentally, methylene blue converts methemoglobin into hemoglobin within 10 minutes, provided the methemoglobin content in the blood has not risen to more than 40 per cent of the total pigment. One milligram per kilogram of body weight is given intravenously to produce this effect. An infant weighing 8 pounds should thus respond to a dose of 0.5 cc.

After the first injection, Sandy's color improved slightly and his respirations became less labored. A second dose was administered half an hour later. By the next morning, his color and respirations were good. He appeared hungry and took the glucose eagerly. All treatments were discontinued and he was placed on a formula using skimmed milk.

Sandy's home was dependent on a well for its water supply. In order to prove that this water was the source of the difficulty, it was arranged that 20 ounces of this well water would be delivered to the hospital to be used in the preparation of the formula. The immediate result was a return of the mottling on the baby's skin. The following day, city water was used in making the feedings. Gradually the discoloration diminished, appearing only slightly when he cried. A week after his admission, Sandy was discharged. During his stay in hospital, the baby's weight had increased approximately half a pound.

Miss MacLachlan is a student nurse at the Regina General Hospital, Sask.

Tests were made on the farm well water. The specimens showed the following results:

(a) *Pumped water:* "Nitrate content 30 times the limit considered safe for infants."

(b) *Pulled sample:* "Nitrate content almost double that of the above test."

The pumped specimen showed no harmful organisms whereas the pulled water, which was drawn several days later, contained "a high degree of bacterial contamination." The different findings were possibly due to the fact that when the parents realized that the well water was the cause of their baby's ailment they stopped using it.

Methemoglobinemia was little known until 1945 when a doctor reported two cases in infants in rural Iowa. Both babies were on artificial feedings made up with well water of high nitrate content. Following publication of his report, many more cases came to light, including 12 patients in rural Manitoba and Ontario. Despite incomplete data on all of these, it can be assumed the diagnosis was the same since their histories were typical and recovery complete as soon as the suspected well water was discontinued. In each instance the patient was an infant under two months of age, fed on an evaporated or powdered milk formula.

The water used in every case came from poorly constructed shallow wells, often situated on low ground and in close proximity to animal contamination. The safe upper limit of nitrate content in well water is placed at 10 parts per million. Wells that have been contaminated by seepage from manure piles, pig-pens, etc., contain an excessive amount of nitrate, in some cases 200 to 300 parts per million.

Methemoglobin is normally present in blood to extent of 1 per cent. Methemoglobin is in itself non-toxic but, as it is unable to carry oxygen, cyanosis and even death may result, if any appreciable quantity of the hemoglobin is transformed into methemoglobin. When water containing nitrates in the safe amount is ingested, they are rapidly reduced to nitrites, then to ammonia and are excreted as such. When greatly increased quantities of nitrates are ingested, either due to nitrate-containing drugs or to contaminated well water as in Sandy's case, the normal mechanism is evidently inadequate. The nitrates are broken down to nitrites and are absorbed as such into the circulation. One molecule of nitrite iron unites with two molecules of hemoglobin to form methemoglobin. In some of the reported cases the methemoglobin level has reached 6 or 7 grams, thus leaving only 5 or 6 grams of functioning hemoglobin.

What I Have Learned

1. Well water methemoglobinemia should be considered as a possible diagnosis in all cases of cyanosis in rural infants under two months of age who are artifically fed (often confused with congenital heart or "enlarged thymus").

2. It does not occur in the breast-fed infant nor in the infant fed undiluted cow's milk.

3. Its occurrence depends on an excess of nitrate present in contaminated well water used in making up infant feedings.

4. Boiling the water has no effect on the nitrate content.

5. Infants recover spontaneously within 36 hours after the correct diagnosis is made and the use of the contaminated well water stopped.

6. Blood tests show blood to be a chocolate-colored fluid which on spectroscopic examination shows a well-marked methemoglobin band.

7. Public health measures should be urged to improve the quality of rural water supplies and prevent the use of any water containing more than 10 parts per million of nitrate in infant formula.

References

1. Comly, Dr. Hunter H. Cyanosis in Infants caused by Nitrates in Well-Water. *American Medical Association Journal.* Sept. 1948, pp. 112-4.

2. Guest, Dr. W. C. (Medovy & Victor). Well-Water Methemoglobinemia. *Canadian Medical Association Journal.* May, 1947, pp. 505-8.

3. Medovy, Dr. Harry. Report. *Lancet* May, 1948, pp. 194-6.

The Death of Oliver Cromwell

RECENTLY, WE WERE privileged to examine a very old newspaper, *The Commonwealth Mercury*, that was published in London, England, as a weekly, covering the events from September 2 to 9, 1658. Each page was slightly smaller than our *Journal* page. There, heavily bordered in black, was the announcement of Cromwell's death. We reproduce part of it with the original spelling and capitalization, though we cannot use the old style "s" that looks like an "f."

The advertisements gave us all a chuckle, too, so we shall share them with you, exactly as they were worded.

His most Serene and Renowned Highness Oliver Lord Protector, being after a sickness of about fourteen days (which appeared an Ague in the beginning) reduced to a very low condition of Body, began early this morning to draw near the gate of death; and it pleased God about three a clock afternoon, to put a period to his life. I would willingly express upon this sad occasion, the deep sorrow which hath possessed the mindes of his most Noble Son and Successor, and other dearest Relations, had I language sufficient: But all that I can use, will fall short of the merits of that most excellent Prince. His first undertakings for the Public Interest, his working things all along, as it were out of the Rock, his founding a Military Discipline in these Nations, such as is not to be found in any example of preceding times; and whereby the Noble Soldiery of these Nations may (without flattery) be commended for Piety, Moderation, and Obedience, as a pattern to be imitated, but hardly to be equalled by succeeding generations: His Wisdom and Piety in things divine, his Prudence in management of the Civil Affairs, and conduct of the Military, and admirable Successes in all, made him a Prince indeed among the people of God; by whose prayers being lifted up to the supreme Dignity, he became more highly seated in their hearts, because in all his actings it was evident, that the main design was to make his own interest one and the same with theirs, that it might be subserving to the great interest of Jesus Christ.

And in the promoting of this, his spirit knew no bounds, his affection could not be confined at home, but brake forth into foreign parts, where he was by good men universally admired as an extraordinary person raised up by God, and by them owned as the great Protector and Patron of the Evangelical Profession. This being said, and the World itself witness of it, I can onely adde, That God gave him blessings proportionable to all these vertues, and made him a Blessing to us, by his wisdom and valor to secure our Peace and Liberty, and to revive the ancient renown and reputation of our Native Country.

After all this, it is remarkable, how it pleased the Lord, on this day to take him to rest, it having formerly been a day of labors to him; for which both himself and the day (*Sept. 3*) will be most renowned to posterity, it having been to him a day of Triumphs and Thanksgiving for the memorable Victories of *Dunbar* and *Worcester;* a day, which after so many strange Revolutions of Providence, high Contradictions, and wicked Conspiracies of unreasonable men, he lived once again to see, and then to die with great assurances and serenity of minde, peaceably in his Bed.

Thus it hath proved to him to be a day of Triumph indeed, there being much of Providence in it, that after so glorious Crowns of Victory placed on his head by God on this day, having neglected an Earthly Crown, he should now go to receive the Crown of Everlasting Life.

. . . This Afternoon the Physitians and Chirurgians appointed by Order of the Council to embowel and embalme the Body of his late Highness, and fill the same with sweet Odours, performed their duty.

* * *

ADVERTISEMENTS

There is newly Published, a few Sighs from Hell, or the Groans of a damned Soul, being an Exposition of those words in the Sixteenth of Luke, concerning the Rich Man and the Beggar; wherein

You know, you do more for your patient than you might think . . .

For instance, your crisp clean uniform and your air of confident grooming go a long way to brighten your patient's day.

But good grooming is more than the morning bath and a bright fresh uniform. *Because perspiration is a continuous process.*

Mum is the *safer* way to preserve morning-bath freshness because it contains no harsh or irritating ingredients—stays smooth and creamy—does not dry out in the jar. And Mum is *sure* because it prevents underarm odor throughout the day or evening. Recommend it to your patients too.

Why take a chance when
you can MUM in a moment?

Safer for charm . . .
Safer for skin . . .
Safer for clothes . . .

Product of BRISTOL-MYERS COMPANY OF CANADA LTD. • 3035 St. Antoine St., Montreal 30, QUE.

WHITE UNIFORM SHOES

Because they are light and airy, attractively styled, and because they are designed on Hurlbut lasts to stand up to a lot of standing up and walking about, "White Uniform" shoes by Savage are the choice of smart young women in the nursing profession.

THE Savage Shoe COMPANY LIMITED PRESTON, ONTARIO

is discovered the lamentable state of the damned, their cries, their desires in their distresses, with the determination of God upon them: A good warning word to sinners, both old and yong, to take into consideration betimes, lest they come into the same place of torment. Also a brief discourse touching the profitableness of the holy Scriptures. By that poor servant of Jesus Christ, John Bunyan. Sold by M. Wright at the King's-Head in the Old-Bailey.

That excellent, and by all Physicians approved, China Drink, called by the Chineans, Tcha, by other Nations, Tay or Tee, is sold at the Sultaness-head, a Cophee-house in Sweetings Rents by the Royal Exchange, London.

Whosoever desireth to be cured of the Rupture, or Broken Belly, of any ages to threescore and ten, let them repair to one Rowland Pippin, who will by Gods help make them whole; the poor for charity, the mean for little, the rich for reasonable terms: He will stand to all charge for the Cure, until they shall finde by experience their own good. He hath taken a Chamber in the Strand, at the Three Pigeons near Somerset-house, where you may finde him all the Forenoons until nine of the clock, and from one to five in the afternoon. He lives in the countrey at Sutton-Brewhouse near Gilford in Surrey; his Father, Brother, and himself, have used this practice this threescore years in the West, where the name of Pippin is remarkable for several cures of this nature.

Sept. 3, in the night, was stole or lost from Mr. Allen's pasture in Hasleigh near Maldon in Essex, a well spread Bay Gelding about 15 hand high, with a black mane and tail, a great white blase in his face, almost ball-faced, the skin of his upper lip white, three white feet, a knot upon one of his fore-legs like a splint, between the knee and the pastern, half

BURSARIES FOR STUDY IN THE FIELD OF MENTAL HEALTH

UNIVERSITY OF TORONTO SCHOOL OF NURSING

Substantial bursaries are available for registered nurses for the Session, 1950-51.

Purpose of the bursaries:

(a) To prepare instructors and supervisors for psychiatric wards *in order to improve the teaching of nurses* in their clinical study of mental health.

(b) To prepare nurses for other work in the field of mental health.

Note: The adequately prepared nurse has one unique qualification for service in the field of mental health, namely, prolonged *clinical experience* resulting in certain knowledge and understanding that can be gained in no other way. Hence, a first step in preparing nurses for future work in this whole field must include clinical experience in the psychiatric hospital.

The course includes:

(a) Clinical and classroom study of mental illness and mental health, ward administration, and principles of supervision.

(b) Principles and methods in classroom and clinical teaching.

(c) Developments in nursing education.

As the bursary covers a period of twelve months, there is opportunity for selected field experience (practice and observation visits) in Toronto and elsewhere.

For further information apply to:

The Secretary,
University of Toronto,
School of Nursing.

DALHOUSIE UNIVERSITY

SCHOOL OF NURSING

Offers both Graduate and Undergraduate Programs of Study for the Term, 1950-1951

1. Graduate Programs:

The School of Nursing offers to Graduate Nurses with Junior Matriculation a program covering one academic year plus two to three months of field experience leading to a Diploma in: (a) Public Health Nursing; or (b) Teaching and Supervision in Schools of Nursing.

2. Basic Program in Nursing leading to B.Sc.N.:

The School of Nursing offers a five-year program in nursing leading to the Degree of Bachelor of Science in Nursing. The degree course provides a basic professional course which prepares the student for hospital and public health nursing.

Further details on application to:

The Director
School of Nursing
Dalhousie University
Halifax, N.S.

as big as a Hen egg, but longer, seven years old, a good drawer, and will amble a little. If any person shall give notice of him to Mr. Richard Kingsman a Grocer, at the yellow Spread-Eagle in Grace-Church-Street, London, or to the said Mr. Allen, he shall have forty shillings reward.

TORONTO HOSPITAL FOR TUBERCULOSIS

Weston, Ontario

THREE-MONTH POST-GRADUATE COURSE IN THE NURSING CARE, PREVENTION AND CONTROL OF TUBERCULOSIS

is offered to Registered Nurses. This includes organized theoretical instruction and supervised clinical experience in all departments.

Salary—$104.50 per month with full maintenance. Good living conditions. Positions available at conclusion of course.

For further particulars apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ontario.

Scholarship Available

The first post-graduate travelling scholarships under the British Commonwealth and Empire Nurses War Memorial Fund are to be awarded in 1950 for courses to be taken during 1950-51. Eight scholarships, each of **£350 sterling,** are available to nurses in various countries.

Canadian nurses are invited to file their applications for the *Thomas Wall Scholarship* which has been especially designated to this country. All applications must be filed by **March 31, 1950.**

CONDITIONS OF AWARD

1. Candidates must be Canadian citizens.
2. Candidates must be active members in good standing of one of the provincial registered nurses' associations.
3. Candidates must have not less than five years' experience after completion of training, exclusive of any post-graduate course.
4. Candidates must have basic qualifica-

tions and experience necessary for the course selected.

5. Candidates must have at least university entrance standing or be able to show evidence of comparable educational standard.

6. Candidates must plan to follow an approved course at a recognized institution of their own choice in a country other than their own. Choice of the course should be stated at the time application is made.

7. This scholarship is for £350 sterling. All expenses, travelling and otherwise, over and above the £350 must be paid by the candidate and guaranteed in advance. The full sum necessary must be available before the nurse leaves Canada.

8. Before the award is made, selected candidates may be required to write an essay on an appropriate nursing topic.

Candidates are advised to make application as soon as possible to:

The Chairman, Scholarship Award Committee
Canadian Nurses' Association
Suite 401, 1411 Crescent St.
Montreal 25, Que.

Foodstuffs Destroyed

An estimated 50 per cent of the entire world output of foodstuffs is destroyed by pests and diseases every year according to a report presented at a recent meeting of the International Congress of Crop Production in London, Eng. Such destruction has added impetus to the drive for an increased use of the many new highly effective insecticides and fungicides which, agricultural experts say, can bring gains to the farmer equal to the gains he now achieves through the application of fertilizers.

—C-I-L Oval

Industrial Health

The average Canadian worker loses nine and a half days every year through sickness and accidents. Most of this lost time is due to illness and *most of it could be prevented.*

Millions of lost man-days represent a heavy loss to both labor and management—a loss which neither they nor Canada's economic structure can afford. For this reason "industrial health" occupies a prominent position in the overall Canadian public health picture.

—Health League of Canada

No. 1 of a series

MODERN RESEARCH

Perhaps, above all other Canadian women, the Nurse understands and appreciates the importance of research . . . whether the research deals with bacteriology . . . or dermatology.

The story of Beauty Counselors' unique plan of sensible skin care is the story of scientific research, carried on in modern laboratories with one purpose in view. This purpose is to develop and supply products which help keep the skin healthy . . . the appearance lovely.

THE STUDY OF ALLERGIES

You will be interested in knowing that a direct result of this intensive, unending, scientific research is the fact that today's Beauty Counselor products are as highly non-allergenic as science can make them. All known allergens have been completely removed, or reduced to an absolute minimum.

What a contribution to the good grooming of the woman who has been unable to use cosmetics because of allergic reaction to them!

If you would like to join the attractive women of three continents who depend upon Beauty Counselors' day-to-day sensible skin care for their loveliness, won't you please drop me a line?

Your trained and gracious Beauty Counselor will call on you at your convenience, in your own home. You are not obligated in any way.

Yours for loveliness

Adalene E. Johnston M.A.

President
Beauty Counselors of Canada, Limited
Windsor, Ontario

THE NEW YORK POLYCLINIC

Medical School and Hospital (Organized 1881)

•

The Pioneer Post-Graduate Medical Institution in America

•

We announce the following Courses for qualified Graduate Nurses:—

No. 1. Operating-Room Management and Technic.

No. 2. Medical-Surgical Nursing — Supervision and Teaching.

No. 3. Organization and Management of Out-Patient Department (Clinics in all branches of Medicine, Surgery — including Industrial Surgery — and Allied Specialties)

Courses include: Lectures by the Faculty of the Medical School and Nursing School; principles of teaching ward management, principles of supervision; adequate provision for practice in teaching and management of the specialty selected. Full maintenance is provided.

For information address:

The Directress of Nurses, 343 West 50th Street, New York City 19

Pasteurization kills disease-producing bacteria, such as those that cause typhoid fever, paratyphoid, acute intestinal infections (acute diarrhea), scarlet fever, septic sore throat (*Streptococcus hemolyticus*), and tuberculosis.

—Health League of Canada

BRITISH COLUMBIA

CIVIL SERVICE *requires . . .*

PUBLIC HEALTH NURSES, Gr. 1

for the Department of Health, Province of B.C.

Salary: $201.50 rising to $228 per month (including current C.L.B.). ***Qualifications:*** Candidates should be eligible for registration in B.C. and have completed a University Degree or certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province; cars are provided.) Further information may be received from the *Director, Public Health Nursing, Dept. of Health, Parliament Bldgs., Victoria.* Candidates must be British subjects, under age of 40 (except in the case of ex-service personnel who are given preference), unmarried, or self-supporting. Application forms obtainable from all *Government Agencies, the B.C. Civil Service Commission, Weiler Bldg., Victoria,* or *636 Burrard St., Vancouver,* to be completed and returned to the **Chairman, Civil Service Commission, Victoria**

Raw Milk Not Safe

Even with the greatest care, raw milk is not safe. Although the agricultural departments are doing a remarkably fine work in weeding out tuberculous and other diseased animals from Canadian herds, this still does not make milk safe. The careful control of the milk-producing cows is not sufficient. Septic sore throat, scarlet fever, and typhoid fever, for example, do not come from the cow, but from the handlers of unbottled, unpasteurized milk. In regard to tuberculosis, even tuberculin-tested cows, although showing a negative test, have been found to develop the disease and produce tubercle bacilli in milk before the next routine tuberculin test was done. Living tubercle bacilli have actually been found in certified milk, formerly produced under the requirements for certification in Toronto.

—Health League of Canada

An important member or adjunct of the circulatory system is the kidneys. According to statistics, nephritis ranks third among the major causes of death in Canada, about 100,000 deaths in the years 1930-45. The function of the kidney is to filter the serum of the blood, to put back into it the necessary constituents, and to wash out of the body in the urine the waste products of protein digestion. *—Health League of Canada*

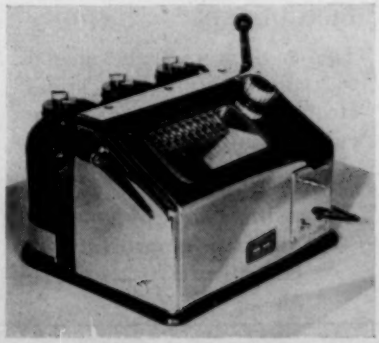
Hypodermic Needles

A machine for cleaning hypodermic needles is now being manufactured and marketed by the *Medical Equipment Laboratories, 5404 Sierra Vista Ave., Los Angeles 38, California.* The Casady Hypodermic Needle Cleaner, invented by Dr. R. R. Casady, was developed to reduce the great amount of time now required for the manual cleaning of the ever-increasing number of hypodermic needles being used. Equally important—it gives dependably clean needles.

Recent hospital surveys have shown that there has been a large and steady growth in the number of hypodermic needles used daily, due to the advancements made in injection techniques and practices. In most hospitals this growth has created a real problem in the amount of time required of personnel for the tedious task of cleaning these needles by hand. Hospitals are also aware of the corresponding growth in the chances of reactions due to poorly cleaned needles.

This machine can cut the amount of time required to clean needles by as much as 80 per cent, and can deliver needles more thoroughly and effectively cleaned than is possible by hand methods. The hubs of the needles are forcefully cleaned by an electrically driven swab. Then the needles are washed with three separate fluids, successively passed through the needles under 20 pounds pressure, followed by a stream of compressed air, leaving them dry and clean. One hundred needles can be swabbed out, washed, rinsed, and dried in nine minutes.

The machine has been designed for long wear, efficient performance, and simplicity of operation.



PSYCHIATRIC COURSE

FOR

GRADUATE NURSES

The **Verdun Protestant Hospital** offers to qualified Graduate Nurses a six-month certificate course in Psychiatry, commencing ***March 1, 1950.***

For further information apply to:

Director of Nursing
Box 6034
Montreal, Que.

THE MOUNTAIN SANATORIUM HAMILTON, ONTARIO

TWO-MONTH POST-GRADUATE COURSE IN THE IMMUNOLOGY, PREVENTION, AND TREATMENT OF TUBERCULOSIS.

This course is especially valuable to those contemplating Public Health, Industrial, or Tuberculosis Nursing.

For further information apply to:

Superintendent of Nurses.
Mountain Sanatorium,
Hamilton, Ontario.

For several years the average length of treatment of tuberculosis patients in our sanatoria has been just under 13 months.

—*Your Health*

Book Reviews

Textbook for Midwives, by Wilfred Shaw, M.D. (Cantab.). 689 pages. Published by J. & A. Churchill Ltd., 104 Gloucester Place, London W.1, Eng. 1948. Illustrated. Price 12s. 6d.

Reviewed by M. Plunkett, Obstetrical Supervisor, Royal Jubilee Hospital, Victoria.

This text is written too much along the lines of midwifery to be of great value as a reference book for student nurses in a school of nursing. It would probably be very useful for nurses in outlying posts who do not always have medical assistance close at hand and are forced at times to rely on their own judgment.

An Introduction to Chemical Science, by William H. Hatcher. 449 pages. Published by John Wiley & Sons, Inc., 440 Fourth Ave., New York City 16. 2nd Ed. 1949. Illustrated. Price (in U.S.A.) $4.00.

Reviewed by Sr. M. Hedwig, St. Elizabeth's Hospital, Humboldt, Sask.

The author has an effective method of presentation of material. It is particularly suitable for beginners in the study of chemistry. The simple, matter-of-fact, yet clear and interesting style is a positive aid to the simplification of this difficult subject.

The very common headings and commonplace language—e.g., "looking and going backward", "chemical long and shorthand"—adds an interesting note to the chapters. The incorporation of the Review of Definitions at the end of each chapter adds a great deal to the simplification and comprehensibility of the subject matter in question. Brief pictorial definitions are given. An exclusive feature of Part I is the incorporation of new chapters on the three states of matter, chemical composition and reaction, acids, bases and salts.

The greatest simplification has been carried out in Part II. The structure of aromatic compounds, their isomers and homologues as well as their behavior with acids and hydroxides, is clearly demonstrated and simplified by an aromatic chart.

The practicality of the chapter on organic chemistry has been greatly increased. This also impresses the student with the fact that organic chemistry is applicable to observations made in everyday life. The special space allotted to pharmaceuticals completes and generalizes organic chemistry to such an extent that it makes the text suitable for those students whose major interest lies in medicine.

Part III gives a well-balanced and concise account of nutritional value of foods, their assimilation, and digestion. The explicit discussion on foods and the very brief yet commonsense treatment of diet proves of maximum usefulness to students of dietetics.

A new feature of Part IV is Chemistry in the Home. The chemistry of food preparation is discussed clearly and simply.

The revised second edition provides a sound foundation of information to students looking forward to a considerable degree of specialization in this or related sciences. It is an up-to-date and practical textbook of basic information.

Nursing Sisters' Association

During the past year, the *Montreal Unit* held two executive meetings and three general meetings. On June 11, the meeting took the form of a garden party at Ste. Anne de Bellevue, where the members were guests of Matron Nancy Kennedy-Reid, R.R.C. With favorable weather, the meeting was highly successful and well attended.

The annual memorial and re-dedication service, held on May 1, brought out many members and was very impressive. The service, at the Church of St. Andrew and St. Paul, was addressed by the Rev. R. J. Berlis, whose remarks were both fitting and moving.

Commemoration Day services were held on May 24 at the Field of Honor, Pointe Claire. The unit was well represented at this function.

Miss V. Facey-Crowther represented the nurses of both World Wars when she placed a wreath at the Cenotaph on Remembrance Day.

At the funeral of E. Frances Upton, R.R.C., R.N., full military honors were accorded. The body was borne on a gun-carriage to the Church of St. James the Apostle, accompanied by a guard of honor of nursing sisters.

THINKING OF A CHANGE?

THE FOAM LAKE UNION HOSPITAL, FOAM LAKE, SASKATCHEWAN—

Offers

Fine Working Conditions. Excellent Salary Structure. Diversified Nursing Experience. Beautiful new Hospital and Residence

For full particulars apply to:

The Superintendent.

THE VICTORIAN ORDER OF NURSES FOR CANADA

Has vacancies for supervisory and staff nurses in various parts of Canada.

Applications will be welcomed from Registered Nurses with post-graduate preparation in public health nursing, with or without experience.

Registered Nurses without public health preparation will be considered for temporary employment.

Scholarships are offered to assist nurses to take public health courses.

Apply to:

Christine Livingston
Chief Superintendent
193 Sparks Street
Ottawa.

ROYAL VICTORIA HOSPITAL

School of Nursing, Montreal

COURSES FOR GRADUATE NURSES

1. A four-month clinical course in **Obstetrical Nursing.**
2. A two-month clinical course in **Gynecological Nursing.**

Salary—After second month at General Staff rates.

For information apply to:

Director of Nursing
Royal Victoria Hospital
Montreal 2, Que.

McGill University
School for Graduate Nurses

1266 Pine Ave. W., Montreal 25

—Bachelor of Nursing Courses—

Two-year courses leading to the degree, Bachelor of Nursing. Opportunity is provided for specialization in field of choice, registering in any of the major fields indicated by asterisk.

—One-Year Certificate Courses—

* Teaching and Supervision in Schools of Nursing.
* Administration in Schools of Nursing.
* Public Health Nursing.
* Administration and Supervision in Public Health Nursing.

Supervision in Psychiatric Nursing.

Supervision in Obstetrical Nursing.

Supervision in Paediatric Nursing.

The social highlight of the year was the annual Armistice Dinner, held on Friday, November 11, in the Prince of Wales Salon at the Windsor Hotel. Nearly 100 members were present. The members were privileged to have as their guest speaker, Kate Aitken, women's editor of *The Standard*. Evelyn Elliott, the president, presided, and Madeline Taylor thanks the speaker. The guests at the head table with Mrs. Aitken and the president were: Misses Macleod, Honey, Henderson, Kennedy-Reid, J. MacKay, Taylor, Paterson, and Mrs. Stuart Ramsey.

Alberta

The following are staff changes in the Alberta Division of Public Health Nursing:

Appointments: *Mary K. Anderson* to the new district nursing centre at Milk River as nurse-in-charge; *Amy Conroy*, a former member of the district nursing staff for many years, has returned to Lindale; *Esther Deering* (Holy Cross Hospital, Calgary) to Dixonville; *Florence Kennedy* (Misericordia Hospital, Edmonton) to Alder Flats; *Marguerite Ries* (H.C.H., Calgary) to Grassland.

Transfers: *K. Ambrose* to Fort Assiniboine, *Nellie Beatson* to Youngstown, *Mrs. K. Coutts* to Lomond, *Mrs. M. C. Faulkner* to Whitecourt, and *Nina Renwick* to Maloy.

Resignations: *Vera Griffith* from Wheatland health unit to be married; *Eleanor Jamieson*, formerly in charge of Athabasca health unit, to take public health course in administration and supervision at McGill University; *Edith Batton*, *Lillian White*, and *Marguerite Weder*.

Gladys (Hutchings) Longson is doing temporary duty at Wheatland health unit, Strathmore. *Esther Bailey* is giving part-time service at Hamaruka. *Anne Nordtorp* has returned from sick leave to Worsley.

News Notes

BRITISH COLUMBIA

KAMLOOPS-TRANQUILLE

The December meeting was held in the new nurses home at Tranquille where Dr. W. Lane, a member of the medical staff, spoke

on "Health Education in Tuberculosis." This informative lecture delivered in an amusing vein was much enjoyed by everyone present.

The sum of $46 was voted for parcels for the British nurses and $5 each for the Arthritic Campaign and the United Nations Appeal Fund.

Miss Betty Stewart was named convener of the nominating committee in preparation for the election of officers in January.

VANCOUVER

General Hospital

Branches of the alumnae association are being formed in various centres like Montreal, Toronto, Burnaby, and Trail. The executive has drawn up "Proposed Regulations for the Organization of the Branches."

At the November meeting of the alumnae, Mrs. Alfred Neal, a direct descendant of one of the coast Indian chiefs, spoke on "Indian Art"—totems specifically. The members also enjoyed a remarkable film on Indian masks, entitled "The Loon's Necklace."

The alumnae is pleased to welcome back to Vancouver one of its honorary members—Ethel Johns. Miss Johns, former superintendent of nurses at the hospital, and for many years editor of *The Canadian Nurse*, has settled in "a little grey home in the west"—West Point Grey, too, and is very busy renewing old friendships and exploring new adventures like furnaces and such! I. Cope, of "S and T and E," retired early last summer. Marjorie McCaul, supervisor of the Maternity Building for many years, has also retired.

St. Paul's Hospital

The alumnae association has decided to make an annual award to one member of each section of the graduating class. The award will be given to the "Best All-Round Student"; the students themselves will select the winners. Presentation of the award was made when the 1950 class was entertained by the alumnae at a buffet supper. The alumnae has also presented the nursing school with a kit to be used in the student V.O.N. affiliation.

The bazaar was a great success. Everything was sold and over $350 realized. Thanks are extended to Mrs. Lane, convener, and her committee.

Elected to the Registry Committee are: President, V. Cooper; vice-president, B. Scott; secretary, I. Pascuzzo; treasurer, M. Fast; staff representative, B. McGillivary.

Sr. Anne Antoinette is congratulated on capturing first place in the R.N. exams in B.C. She was presented with a watch by the alumnae to commemorate her accomplishment.

MANITOBA

BRANDON

Mrs. E. Griffin, the president, was in the chair at a recent meeting of the Associa-

Proven successful treatment for

PEDICULOSIS CAPITIS

SULEO DDT Hair Emulsion *eradicates* and *prevents* Head Pest Infestation—is non-inflammable—undetectable in use . . . no fine combing required.

The British Medical Journal says: "Every case so far treated with DDT Emulsion has been cured by one application. This result is to be expected, as the duration of protection with DDT exceeds the incubation period of the nits". (March 24th, 1945).

On sale at all druggists. . . 3 oz. bottle 50¢ Write for pamphlet and professional sample to: J. M. Inwood Limited, 406 Hopewell Ave., Toronto 10.

SULEO D.D.T. *hair emulsion*

Experienced Nurses Know What Baby Needs at Teething Time

WHEN baby is teething, fretful, suffering from constipation, colic or other minor upsets . . . experienced nurses know that Steedman's Soothing Powders bring prompt relief. Safe, gentle, easy to give—used the world over for 100 years. Eight out of 10 druggists recommend Steedman's, too . . . the fastest-selling product of its kind in Canada.

STEEDMAN'S
SOOTHING POWDERS
For Teething Babies

REFERENCE MANUAL
FOR
MEDICAL ETHICS

By CHARLES J. McFADDEN
VILLANOVA, PA.

This Reference Manual contains the solutions to the "Problems for Discussion" at the end of each chapter of the author's text, *Medical Ethics for Nurses*. The book includes a wealth of pertinent material which is most helpful to both student and teacher. The demand for a manual to accompany the text has come from many quarters. $1.75.

THE RYERSON PRESS
TORONTO

ALGYNOX
80% RESULTS
DYSMENORRHEA
POST PARTUM PAINS
Tubes of 10,
Bottles of 100 tablets.
ROUGIER FRÈRES
350 LEMOYNE STREET, MONTREAL 1

THAT ALL UNIFORMS CLOTHING AND OTHER BELONGINGS ARE MARKED WITH
CASH'S Loomwoven NAMES
Permanent, easy identification. Easily sewn on, or attached with No-So Cement. From dealers or CASH'S, Belleville 5, Ont.
CASH'S: 3 Doz. $1.65; 9 Doz. $2.75; NO-SO NAMES: 6 Doz. $2.20; 12 Doz. $3.30; 25c per tube

tion of Graduate Nurses. Appreciation was expressed to Nan Creighton, who is to be married, for her interest in the association and a small gift was presented to her by Mrs. Peirce. "Thank you" notes were read by Mrs. Peirce from Miss Lane, who had received parcels at her hospital overseas from the association. A vote of thanks was tendered Mrs. R. Russell for her able convenership of the successful dance in aid of the Scholarship Fund.

Following the business session, Mrs. W. J. Anderson's group took charge and presented Mrs. F. L. Grant with several of her pupils in a variety of vocal numbers.

Members of the General Hospital staff entertained at the tea hour in honor of Miss Creighton when a gift was presented to her. The 1949 graduating class also entertained for her at the home of Isobel Zeigler. Another social gathering was held in her honor at the Mental Hospital. Miss Creighton will make her new home on a farm about 40 miles from Brandon.

NEW BRUNSWICK

CAMPBELLTON

A course in nursing pedagogy and ward supervision was conducted at the Hotel-Dieu. Sister Jeanne Saint-Louis, s.g.m., of Institut d'Youville, University of Montreal, gave a series of 32 lectures. Taking this course were 36 sisters and nurses from most of the hospitals in the north of the province. The course was given under the auspices of the Sacred Heart University, Bathurst.

SAINT JOHN

General Hospital

On December 22 the Christmas season began for the student nurses. The Christmas tree standing in the corner of the big living room was turned into a brilliant spectacle of tinsel, lights and multi-colored ornaments. During the evening the girls practised Christmas carols and it sounded wonderful. A carol service was held by the Student Nurses' Christian Fellowship. The program consisted of the Christmas Story presented with scripture readings and carols. Scripture was read by Miss Lois Floyd with background piano music by Miss Dorothy Morehouse and carols by nurses of the Fellowship Group. Short talks were given by Miss S. Black and Nora Murchison, two graduates of the school. We feel certain that this carol service will be an annual Christmas event.

The Christmas party took place on Friday evening. This is always a very gay occasion and this was one of the happiest parties ever held. Santa Claus visited the party and presented gifts to the girls. One of the guests at the party was Miss Margaret Murdock. Carols were sung and the favorite reading, "Twas the night before Christmas," was given. Refreshments were served.

Christmas Eve was spent quietly but happily. Gifts were opened before sparkling eyes of room-mates and friends. Visits were made from room to room and the decorations here were "works of art."

Sunday morning, the day students along with supervisors sang Christmas carols in the hospital. Each nurse carried a lighted, white candle and the effect was inspiring.

The formal Christmas Dance was held on December 28 in the residence, sponsored by the senior class. The rooms were gaily decorated in Christmas colors and soft fluffy snow-balls hung from the ceiling. Miss O. J. Smith, director of nurses, and Miss Marguerite Stuart, president of the senior class received the guests. Refreshments were served and everybody seemed to have a wonderful time. Although for many of the girls it meant being away from home at Christmas, with the exciting events to participate in the students had a very merry Christmas.

Mrs. Eli Boyaner, who recently returned from a trip to Israel as a delegate of the Women's International Organization for Rehabilitation through Training, aroused keen interest in her audience when she told what she had seen to the members of the Saint John General Hospital Alumnae. The alumnae met in the nurses' residence with the president, Miss Beatrice Selfridge, in the chair. Two food parcels for overseas nurses were packed ready for shipment, the members having brought the contents of the parcels to the meeting. They also brought with them articles which were used for a bring-and-buy sale to augment the funds.

ONTARIO

DISTRICT 4

Hamilton General Hospital

E. Ferguson, president, presided at the annual meeting of the alumnae association. After a brief business discussion, Miss Howard, social convener, introduced the guest speaker, Dr. Harry Hotz, pediatrician. He gave a vivid description of Hawaii, showing colored pictures he took while working on the island.

Miss Ferguson will continue to serve as president of the alumnae with C. Graham and G. Blyth as vice-presidents. The recording and corresponding secretaries are M. Cameron and J. Harrison. J. Tufford will serve as Miss Cameron's assistant. D. Cosford is treasurer, assisted by H. Cosford. M. Morrow is secretary-treasurer of the Mutual Benefit Association.

QUEBEC

MONTREAL

Herbert Reddy Memorial Hospital

Several of our graduates are now living or working in the United States. Frances (Fowler) Janzen is busily engaged in industrial nursing in Chicago, Ill. Adele (Gulnick) Manning does floor duty in a Las Vegas, Nevada, hospital. Madeleine (Smith) Barron works in San Francisco as a public health nurse.

Gabriel Brochu is taking a post-graduate course in surgery at St. Michael's Hospital, Toronto.

Good As Gold

What a difference from the fretty, feverish, restless baby who worried Mother such a short time ago! Yes, for the quick relief of constipation, digestive upsets, teething troubles and other minor ailments, Baby's Own Tablets are proving their effectiveness daily in thousands of homes — as they have for over half a century. If desired they may be easily crushed to a powder, and, as they contain no narcotics, opiates or toxic ingredients may be administered with entire confidence.

BABY'S OWN TABLETS

PRACTICAL ADVANTAGES of Vapo-Cresolene THERAPY IN Respiratory Cases

PROMPT ACTION
— through direct contact of vapors with inflamed respiratory membrane.

NO DIGESTIVE UPSET
— since the vaporized drug by-passes the gastrointestinal tract.

WORKS DURING SLEEP
— relief at night; promotes rest.

Vapo-Cresolene is recommended in Bronchitis, Bronchial Asthma, Spasmodic Croup, Whooping Cough. Excellent for children's stuffy nasal colds.

PRESCRIBED SINCE 1870

Send for special brochure

ELECTRIC VAPORIZER

THE VAPO-CRESOLENE CO.
62 Cortlandt St. New York 7, N. Y.

SACRED HEART UNIVERSITY

BATHURST **NEW BRUNSWICK**

Courses leading to the degree of **Bachelor of Science in Nursing** are available for French-speaking nurses engaged in hospital work.

Lectures are presented in summer sessions over a period of four years with extra-mural study and research during the rest of the year.

Field trips of a month during the four years are required of each student. Opportunities are arranged for observation and experience in larger centres such as Montreal, Quebec, and Toronto.

The basic professional curriculum is provided by the University faculty. Qualified specialists are provided from larger centres for the subjects pertaining especially to nursing.

For further information write to:

Mother Ste. Thérèse
Secretary, Nursing School Division
Sacred Heart University
Bathurst, N.B.

Positions Vacant

Advertising Rates — $5.00 for 3 lines or less; $1.00 for each additional line.

Nursing Arts Instructor, Science Instructor, and Clinical Instructor, for a 425-bed hospital. Degrees required. Apply Director of Nursing, Holy Cross Hospital, Calgary, Alta.

Registered Nurses for General Duty required for University of Alberta Hospital, Edmonton. (640 beds). Gross salary: $170 per mo. 1st year, $180 2nd year and $190 3rd year of service in hospital. $25 per mo. deducted for meals and laundry. Statutory holidays. Sick leave: 3 weeks after 1 yr. service, with annual increase of 1 wk. to a maximum of 13 wks. Blue Cross coverage on a 50% employee contributory basis. 1st class railway fare to Edmonton refunded after 1 year continuous service. Pleasant university environment. Apply Supt. of Nursing Services.

Assistant Superintendent for small well-equipped hospital. Operating-room and x-ray experience desirable or willingness to learn. State qualifications and salary expected in first letter to Supt., Saugeen Memorial Hospital, Southampton, Ont.

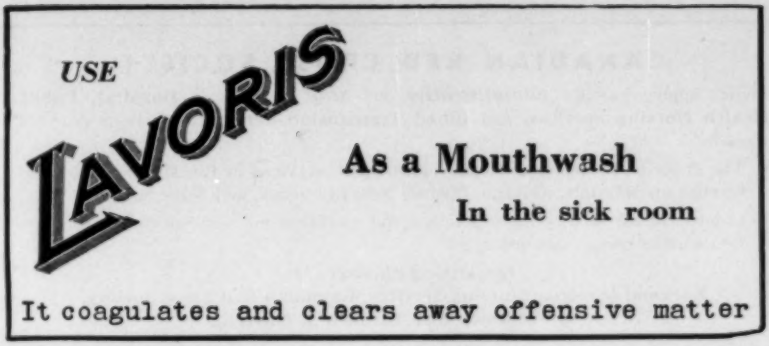
Graduate Nurses (2) for General Duty. Salary: $142.50 per mo., cost of living bonus, increase of $15 per mo. annually up to maximum. Pension, Blue Cross, medical services, full maintenance, uniforms. 8-hr. day, 5-day wk. Vacation with pay. Statutory holidays. Apply Supt., Fred Adams Hospital (Isolation), 2243 Byng Rd., Windsor, Ont.

Asst. Supt. for 76-bed hospital by April. Apply, stating age, qualifications, experience & salary expected, Supt., Chipman Memorial Hospital, St. Stephen, N.B.

Nursing Arts Instructor & Educational Director immediately. The hospital, located in capital city, is connected with large clinic & college which aids greatly in teaching students. Apply Director of Nurses, Evangelical Hospital, 6th & Thayer, Bismarck, North Dakota.

Operating-Room Supervisor for 350-bed General Hospital with Nursing School. Operating-Room occupies one floor of wing just opened; completely modern equipment. Applicant must have O.R. experience & recognized post-graduate course. Basic salary: $205 with consideration for experience. Apply, stating age, qualifications & experience, c/o Box 40, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

General Duty Nurses. 8-hr. broken day. 48-hr. wk. Gross salary: $163.40 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.



Registered Nurses for General Staff Duty for the Division of Tuberculosis Control required by British Columbia Civil Service—***Vancouver Unit:*** 225-bed T.B. Hospital, located at 2647 Willow St., Vancouver. All major services & student affiliation course. Registration in B. C. required. *Gross salary:* $182 per mo. Annual increments of $60 (over 5-yr. period). No residence accommodation. ***Tranquille Unit:*** 350-bed T.B. Hospital, located 12 miles from Kamloops in southern interior. All major services except student affiliation. *Gross salary:* $188.50 per mo. Annual increments of $60 (over 5-yr. period). New modern residence; attractive bed-sitting-rooms; recreational facilities. Maintenance deduction: Room $5.00, laundry $2.50. Excellent food at 20 cts. per meal. ***Conditions—Both Units:*** 8-hr. day, 5½-day wk. Rotating shifts. 4 wks. annual vacation with pay plus 11 statutory holidays. Sick leave 20 days per yr.—14 cumulative. Promotional opportunities. Superannuation. Write for information & applications to Supt. of Nurses of respective Units or to Director of Nursing, Division of T.B. Control, 2647 Willow St., Vancouver, B.C.

Operating-Room Nurses for large active Operating-Rooms in General Hospital, Winnipeg, Man. 48-hr. wk.; straight shift. Information concerning hours, salaries, etc., will be provided on receipt of application, stating preparation, experience & qualifications of nurse. Apply Supt. of Nurses.

Maternity Nurses—post-graduate training preferred, not required. 48-hr. wk.; straight shift. New Maternity Pavilion opening in near future. Information concerning salaries, sick time, etc., provided after application has been received, giving qualifications, years of experience, etc. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

Graduate Dietitian at Ontario Hospitals in Kingston, Whitby, Woodstock. Initial salary: $2,140 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. at above hospitals.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, Kingston, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock & Toronto Psychiatric Hospital. Initial salary: $1,840 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. of Nurses at above hospitals.

Graduate Nurses for General Duty. Gross salary: $171 with bonus of $5.00 when registered in British Columbia. Annual increments. Statutory holidays. Good living accommodation & cafeteria service at reasonable cost. Apply Supt. of Nurses, West Coast Hospital, Port Alberni, Vancouver Island, B.C.

General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $115 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end ea. mo. 1 mo. annual vacation. 14 days sick leave. Apply Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Nurses—appeal to those who wish to contribute to the development of young Canadians. 65-bed hospital. Basic gross salary: $175 plus substantial bonus. Rotating shifts. Room, board & uniform laundry provided at $25 deduction. Staff housed in modern 4 & 6 single bedroom cottages on waterfront. Excellent opportunity to gain experience in Orthopedic & Pediatric Nursing. 26 miles from Victoria. Apply, in writing, giving date of graduation, training school, age & experience, Asst. Supt., Queen Alexandra Solarium for Crippled Children, Cobble Hill, V.I., B.C.

CANADIAN RED CROSS SOCIETY

invites applications for ***Administrative*** and ***Staff*** positions in **Hospital, Public Health Nursing Services,** and **Blood Transfusion Service** for various parts of Canada.

- The majority of opportunities are in **Outpost Services** in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia.
- Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

For further particulars apply:

National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ontario.

Registered Nurses. 8-hr. rotating shift. Cumulative sick leave. All statutory holidays after 3 mos. employment. Gross salary: $145 days; $150 evenings & nights. Residence facilities available. Apply A. D. Potts, Director of Nursing, General Hospital, Belleville, Ont.

Graduate Nurses for General Floor Duty. Salary: $115 per mo. Full maintenance & laundry. $60 yearly increase up to 3 yrs. Apply, stating qualifications, Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, Que.

Graduate Nurses for completely modern West Coast hospital. Commencing salary: $185 per mo. less $40 for board, residence, laundry. Special bonus of $10 per mo. for night duty. $10 annual increment. 44-hr. wk. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. accumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Floor Duty Nurse. 8-hr. duty. Salary: $110. Full maintenance & laundry. Blue Cross hospitalization. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Hospital Matron to take charge of small hospital located in a Crown Community near Medicine Hat, Alta, Must be a graduate of a recognized nursing school, eligible for registration as a nurse in Province of Alberta & have experience in hospital administration. Initial salary: approximately $2,340 per annum, depending on qualifications & experience. Apply, stating age, education & experience, P.O. Box 154, Medicine Hat, Alta. (All replies will be treated as confidential.)

Director of Nursing for large General Hospital with School for Nursing averaging 150 students. Applicants should give full details of education, post-graduate training, experience, references, etc. Correspondence invited. Apply c/o Box 50, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Registered Nurses for Westminster & Sunnybrook Hospitals, London & Toronto, Ont. Salaries: $1,920-2,460 plus uniforms. Information & application forms available at Post Offices or Civil Service Commission of Canada. Applications should be filed with the latter at 1207 Bay St., Toronto 5, Ont., as soon as possible.

Vancouver General Hospital requires **General Staff Nurses.** Salary: $177 increasing to $207. Extra premium for evening or night duty. Registration in British Columbia required. For further information apply Director of Nursing, General Hospital, Vancouver, B.C.

Night Supervisor, capable of taking charge of hospital, including delivery room. **Head Nurse,** qualified to teach & to administer ward. **Scrub Nurses** (2) for Operating-Room. Apply Director of Nursing, General Hospital, Belleville, Ont.

General Staff Nurses (2) for hospital in gold mining community in Caribou District. Minimum salary: $175 per mo. R.N.A.B.C. Personnel Policies in effect. After 6 mos. service transportation refunded from anywhere in British Columbia. Apply Placement Advisor, Registered Nurses' Ass'n of B.C., 1101 Vancouver Block, Vancouver, B.C.

Dietitian for 188-bed hospital. Salary: $175 with full maintenance. 44-hr. wk. For full particulars apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Nursing Arts Instructor & Science Instructor for Nursing School, Holy Family Hospital, Prince Albert, Sask. Submit statement re qualifications & salary expected to Director of Nursing.

General Duty Nurses. Salary: $165 per mo. plus full maintenance, laundry, 2 wks. vacation per yr., sick leave. Apply City Hospital, 828 S. Cedar St., Owatonna, Minnesota.

WANTED

GENERAL DUTY NURSES

For 400-bed hospital. New Wing just opening. 8-hour day, 44-hour week. 10 statutory holidays. B.C. registration required.

Salary: $175 basic. Credit for past experience. Annual increments. ***Vacation:*** 28 days after 1 year. ***Sick Leave:*** 1½ days per month, cumulative.

Apply **Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.**

Supt. of Nurses for 200-bed Hospital & Training School. Salary open. Apply, stating qualifications & experience, Administrator, Victoria Public Hospital, Fredericton, N.B.

Night Supervisor & General Duty Nurses (2). Apply, stating experience & qualifications, Supt., Queens General Hospital, Liverpool, N.S.

Matron—duties to commence March 15. State salary desired. **General Duty Nurse** immediately. Starting salary: $125 per mo. with full maintenance. For Municipal Hospital, Elnora, Alta.—new 15-bed hospital with pleasant working conditions. Hospital board will pay railway fare if employment is for 6-mo. period or more. Apply A. J. Schmiedl, Sec.-Treas., Elnora, Alta.

Colgate Products Guaranteed Uniform Quality

TEXOLIVE KWIKSOLV

KWIKSOLV comes in quick-dissolving form for faster safer washing. Blankets and all knitted things wash softer in Kwiksolv.

ARCTIC SYNTEX "M"

Neutral synthetic detergent, especially useful for washing in the cold water and acid solutions which protect fugitive colours.

GOLDEN XXX CHIPS

Washes more thoroughly at moderate temperatures 150° - 160°F . . . rinses easily, saves hot water and fuel.

FREE WORKING SAMPLE **NEW IMPROVED PHOSFOAM**
FOR WHITER WASHES — CLEANER MACHINES

Write on business letterhead to

INDUSTRIAL DIVISION **COLGATE, TORONTO 8**